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28 MARCH 1986

Worldwide Report

EPIDEMIOLOGY

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WORLDWIDE REPORT
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INTER-AFRICAN AFFAIRS

BRIEFS

LUSOPHONE HEALTH MINISTERS MEET--The ministers of health of the five Lusophone countries in Africa, who have been meeting in Angola since Monday and whose sessions ended on Wednesday, were greatly satisfied with the results of the group's activities in the area of sanitation, especially in the realm of the cooperation undertaken in the field of human resources and medicine. According to the final communique, the participants--with the exception of Guinea-Bissau--emphasized as being among the actions planned and implemented the agreement to harmonize their policies and strategies for international meetings; the introduction of Portuguese as a working language within the WHO Regional Committee for Africa; and the creation in Luanda of a center for higher education in the field of nursing. The communique pointed out that in the area of human resources, for which Angola has been asked to provide new impetus, a study is to be made and proposals developed for the actions needed in order to evaluate health workers at all levels on a continuing basis and to attempt to standardize criteria and decisions common to the "Five". It was also agreed to continue with the ongoing study of equivalence and curricula for basic and specialized medical staff, and to have a chart drafted for each country showing the needs and availabilities in terms of technicians. It was also decided to activate a program for the exchange of specialists, particularly at the teaching level, so that postgraduate and clinical practice juries may be formed. In the area of medicines, the meeting decided to set up a new subgroup, under the leadership of Mozambique, to draft specific proposals to standardize national formularies and work on group purchase of medicines, quality control, and improvement in the training and exchange of pharmaceutical workers. The subgroup was also asked to hold a meeting in Cape Verde of pharmaceutical company directors and officials of the pharmaceutical sector from the five countries sometime during the first half of 1986. [Text] [Bissau NO PINTCHA in Portuguese 25 Jan 86 p 5] 12830/13045
CSO: 5400/72

BANGLADESH

BRIEFS

DIARRHEA DEATHS INCREASE--Diarrhoeal death toll in Jhalakati district rose to 303 with the death of 35 more persons over the last 18 days. Nearly 3,000 persons were also attacked by the disease including 461 who were attacked during last 18 days. According to official record upazilawise figures of the dead and the attacked were: Rejapur 143 and 147, Kathatia 72 and 609, Nalchity 53 and 465, Jhalakati Sadar 31 and 245. When contacted the Civil Surgeon of the district said all possible measures had been taken to check the epidemic. Twenty-six medical teams are still working in the affected areas. [Text] [Dhaka THE NEW NATION in English 20 Jan 86 pp 1, 8] /13104

CSO: 5450/0114

BRAZIL

BRIEFS

AIDS CASES REPORTED--Rio de Janeiro, 26 Feb (EFE)--The Brazilian Health Ministry today confirmed that 625 AIDS cases had been recorded throughout Brazil up to 20 February 1986. A total of 304 people have died from the disease. The largest number of cases--463--were recorded in Sao Paulo State. The same sources stated that 365 cases were recorded among homosexuals and bisexuals, and 30 cases among hemophilics. Five people caught the disease after blood transfusions; 6 were drug addicts; 18 were not identified; and in 186 cases the risk factor was ignored. People in the 30-39 age bracket were the most affected, recording 195 cases, followed by people in the 20-29 age bracket with 143 cases. Thirteen AIDS cases were recorded in children less than 9 years old. In 142 cases, the age was not reported. [Text] [Madrid EFE in Spanish 1303 GMT 26 Feb 86] /9604

CSO: 5400/2042

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CANADA

ISSUES FACING NATIONAL HEALTH CARE SYSTEM EXAMINED

Ottawa THE WEEKEND CITIZEN in English 15 Feb 86 pp B1, B16

[Article by Neil Macdonald: "Our System Among Best in the World"]

[Text]

Canada's health care system costs nearly $39 billion annually. How well is it working, what problems does it face and what are the alternatives? *Citizen* reporter Neil Macdonald spoke to health professionals, patients, politicians and others across North America. In the first of a series, he looks at the issues facing the system which costs $1,500 for every man, woman and child.

The system that takes care of the ailments of Canadians, our security blanket, the safety net to which any permanent resident is entitled, has two outstanding characteristics.

First, it is perverse. It encourages financial irresponsibility, mediocrity, and sloppy planning. It is a government-administered system of negative incentives. All the factors that traditionally promote efficiency, value for dollar and excellence are missing. The Canadian approach to health care is, essentially, to present hospitals and specialists with a blank cheque.

Second, it works. It delivers better value for dollar than the American system, and better care than the British system. It cuts across income, class and geography. Everybody has a ticket to the ball game. The rich heart patient and the poor heart patient, everything else being equal, have an equal shot at the transplant. It is a kinder system than elsewhere. You are not alone in Canada.

Not surprisingly, it is tremendously popular with Canadians. Various studies on the subject have shown more than 90 per cent support for the status quo.

Whatever the value for dollar, though, Canadians still spend an astonishing amount on health care. In 1985, we spent about $38.5 billion — that is thirty-eight and one half thousand million dollars — on health care, or about $1,500 per person. Of that, $8 billion is private money, spent on such things as drugs.

The federal government, which constitutionally must help pay for Canada's approximately 1,100 hospitals and underwrite the salaries of the doctors, contributed about 40 per cent, the provinces the rest.

All that does not count the cost to private companies and their insurers, which have to pay each time an employee books off sick.

The cost of Canada's social programs, most notably our universal medicare, is popularly blamed for the size of the deficit, and, hence, the weakness of the dollar abroad. Earlier this month, the parliamentary secretary to Energy Minister Pat Carney was holding medicare responsible for the disparity between American and Canadian gasoline prices.

There are those who believe that whatever the value for dollar delivered, we spend too much.

It was during and shortly after the deep recession of 1982 that the mutterings of discontent among fis-

cal conservatives in Canada began to focus into a chorus of concern and worry about the sheer amount spent on health.

They have a right to be frightened. For as much as the system copes well with the needs of Canadians now, extreme new problems are appearing that in the near future will result in one of two things, should the system continue as it is: heavy tax increases or equally heavy cuts in the quality of care.

- The aging population. There is no single bigger problem ahead. Nearly half the health care dollar is spent on those older than 65. About one of 10 Canadians is now in that group. But we are living longer, and fewer are dying young. By the year 2020, it will be one in five. The arithmetic is not complicated. Besides which, the 65-year-old of 2020, today's 26-year-old, will demand a more pampered existence than the modern senior citizen, who has gone through a depression and at least one world war.

In England, the National Health System begins rationing treatment after the age of 65. Kidney dialysis, for instance, is withheld after a certain age. Do Canadians want to face that?

- New technology and drugs. Modern science keeps producing atrociously expensive hardware, and software, to treat disease and prolong life. That's a multiple cost. The equipment costs money, the doctors and technicians to run it cost money, the hospital bed used during the treatment costs money, and, once his life is prolonged, the patient costs money to keep alive. Add to that the fact that the institutions are aging, and existing hardware wears out.

- Liability insurance. Although it has not yet come close to the U.S., Canadian society is becoming more and more litigious, and the awards in successful lawsuits are growing. In the health care field, $14 million was awarded to plaintiffs in 1985. But it is the "slopover" effect from the U.S. that is pushing premiums here out of sight.

- New diseases. AIDS, acquired immunodeficiency syndrome, is the biggest, and most prevalent example. And a heavier caseload of known diseases. In 1983, there were 19,000 new cases of cancer in Canada. In 1984, there were about 31,000. Again, the arithmetic isn't difficult.

And there are other problems, by no means new. University of Ottawa health economist Pranial Manga sums them up nicely in a 1981 study: "The increase in the supply of physicians, the profusion and diffusion of technology, inefficient health care delivery systems . . . the rapid rise in health workers' incomes, unnecessary hospitalization, excessive average length of stay, and unnecessary surgery."

Groping for solutions, and faced with an electorate that would excoriate any politician who cut accessibility, quality or service, the administrators of Canada's social medicine are experimenting with means of suppressing cost.

The most often mentioned, and easily the most explosive, is privatization — opening the health care system to the cost-conscious, and, by nature, highly greedy private sector. At the core of this idea is the belief that private-sector management is, *ipso facto*, better and more efficient than the public sector.

Last year, federal Health and Welfare Minister Jake Epp commissioned a report on privatization by former Manitoba health minister Bud Sherman. This year, the Canadian Hospital Association issued a position paper condemning the idea. Health care economists across the country have jumped into the debate, publishing numerous papers of numerous opinions, usually negative, on the subject.

Sherman's $50,000 conclusion was what Epp admits he already knew: there might be some room for contracting out certain non-medical hospital services — food and laundry, for example — but there is no proof that any saving would result by letting businessmen treat and cure us.

"There are examples in Canada," notes Sherman, "of publicly administered hospitals that do not appear to be well run, that chronically report deficits, and that seem to operate in a state of ongoing, incipient crisis. There are others that run superbly."

There is no need to fix the hospitals that already work, argues Sherman. As for the others, many have fund-raising problems because of the income levels in their areas. While an injection of private cash couldn't hurt, notes Sherman, there's no proof it would help, either.

"Private management is more admired by Canadian health system commentators for its characteristics than its motives," said Sherman. "They see it very often as far outpacing the public sector in imagination, innovation, creativity, risk-taking, decision-mak-

ing, fiscal responsibility and accountability."

It is a lovely notion — bring the public-sector wastrels to heel with a healthy dose of hard-headed business sense. In elementary language of the economist, allow the businessman to pursue his own selfish interests, thereby acting to the benefit of all.

And then there is reality.

In America, where the competitive model reigns and the medical marketplace is uncuffed, nearly 11 per cent of the country's gross national product is spent on health care. In Canada, the figure is nine per cent.

And administrative costs — a good indication of where the fat is — run at 16 per cent in the U.S., compared to the two to four per cent Canadian figure. That can be explained by simple economy of scale. Canada is, really, one big system. The U.S., with its mixed market, is hundreds of systems. The American system has more computers, more forms, more staff and more duplication of service.

Still, the amount Canadians have spent on health care each year since 1980 has far outpaced annual rates of inflation — health care is a highly inflationary area.

It is true — and it is often pointed out by the free-market advocates — that average length of stay in private, for-profit hospitals is shorter than at public hospitals.

The reason is less often quoted. For-profit hospitals are careful to choose high-profit, low-acuity, short-stay operations — cataract removal, cosmetic surgery, obstetrics — leaving the extremely high cost items such as renal dialysis, coronary surgery and chronic acute care to the publicly supported institutions.

Many, however, do agree there is a lot more room for the profit-making businessman in the area of geriatric care. With senior citizens, the line between medical care and residency blurs. Whereas the senior is entitled to the same level of medical care as anyone else, why, the argument goes, should the taxpayer pay his rent, too?

If a senior cannot be cured of a condition, and must be in an institution, is there no way to separate the medical portion of the cost from what is, really, free rent?

Ontario, the most experimental of the provinces, says there is, and allows far more for-profit extended care than most of the others.

But generally, As U of O's Manga points out, "the free market model does not apply very well to health systems... providers can create a demand for their own services, and consumers lack information."

No one, however, denies the perverse incentives in the Canadian system.

In most provinces, for instance, hospitals are given a budget by the government. If the institution ends the year with a deficit, the province picks up the tab — it has to. But if the hospital holds the line on spending, there probably won't be an increase in the following year's budget.

And from the point of view of the specialist or surgeon, the fuller the hospital, the better. They don't get paid for keeping people out of hospital beds. There is nothing to prevent the general practitioner, or the specialist, from ordering a whole battery of tests when one would do.

Excessive length of stay? Yes. Dr. Ted Boadway, a former GP and now director of professional services for the Ontario Medical Association, admits it happens.

"Put yourself in the doctor's shoes. You feel a patient is ready to go home, but she doesn't, maybe because she truly doesn't feel well, or her husband can't get the rest of the week off.

"Believe me, I've had this happen. The family is suddenly in the administrator's office dancing on his desk, calling their MP, you name it. Why not let her stay? Who needs the headache?"

Although academics like Manga insist the greed of doctors is mostly responsible for the push to change the system, Boadway says the OMA wants to find ways to cut costs, even though that obviously means less money for the doctors.

"It is a long-range thing. There

is only so much money. Unless economies are found now, there'll be a lot less money in the future."

Ken Fyke, the hard-nosed director of the Greater Victoria Hospital Society, an amalgam of three hospitals that has produced the largest institution in the country, begins looking at his watch when he's asked about the funding crisis in health care.

"It seems there's a crisis every couple of years, and the solution is always: 'The system is a good one, don't raise taxes, try to be more efficient.'"

This is obviously a conversation Fyke has had many times in the past, and he comes to the point rather quickly: Talk of a funding crisis in health care is nonsense. There are precisely as many dollars available as the taxpayers are willing to pour in, and with 94 per cent of the population opposed to any substantial change in the system, "The people will likely pay more, and willingly, if they have to."

Not that they should, says Fyke.

Too many dollars, he says, are thrown away on high-profile, high-cost operations like transplants and open-heart surgery, which in many cases simply stave off the inevitable by a few weeks. The money should be spent, he argues, on high-return areas like prenatal, neonatal, and on preventive medicine.

"But everyone is acute-oriented, today-oriented. If you are a smoker, and diagnosed tomorrow as having lung cancer, you will want the very best and most expensive treatment, right away. Should you be entitled to that?"

Fyke thinks it would be sensible to beef up community support systems for the elderly (geriatric care is a specialty in Victoria), allowing hospitals to free up some of the 10 per cent of acute-care beds now occupied by those over the age of 65.

That done, the beds could be closed.

"Occupancy rate is a very elastic thing. First, you have to understand that there is a never-ending appetite for beds. Whenever there is a supply, there will be a demand. It is just drawing the line, that's all."

Peter Carruthers manages another successful medical institution, Ottawa's Civic Hospital. Four years ago, in an effort to control the number of deficits in the province, Ontario changed its rules to allow any hospital earning a surplus to keep it.

The Civic, well run and able to depend on an affluent community for donations, rolled up a $1.4-million surplus last year, which it is putting toward a new CAT scanner. Carruthers has had a small shopping centre built on the ground floor of the institution. It racked up $2.1 million in sales last year.

But he is facing inflation of 5.2 per cent, and an increase of 3.9 per cent from the province this year.

And equipment is aging. Whereas the standard rule of thumb in private industry is replacement of 50 per cent of capital assets every five years, hospitals face a period of 15 years.

Yet Carruthers hasn't many complaints, other than the familiar Canadian plea for more community support in geriatrics.

Of the Civic's 923 beds, 90-100 are usually occupied by patients awaiting transfer to long-term institutions.

"A guiding principle of the Canadian system has been 'a balanced, integrated system,'" says Carruthers. "We will not have that until we stop institutionalizing our elderly instead of taking care of them.

Health Care Expenditures

CANADA

	Total expenditures (in billions of current dollars)	Percentage increase	Percentage of gross national product	CPI (inflation)
1980	$22.2	—	7.4%	10.2%
1981	$26.1	17.5%	7.7%	12.5%
1982	$30.4	16.4%	8.5%	10.8%
1983	$33.4	9.8%	8.6%	5.8%
1984	$36.3	8.6%	8.6%	4.4%
1985	$38.5	6%	8.6%	4%

U.S.

	Total expenditures (in billions of current dollars)	Percentage increase	Percentage of gross national product	CPI (inflation)
1980	$247.5	—	9.4%	12.4%
1981	$285.8	15.5%	9.7%	8.9%
1982	$321.2	12.4%	10.5%	3.9%
1983	$355.1	10.5%	10.7%	3.8%
1984	$387.4	9.1%	10.6%	4.0%
1985	N/A	N/A	N/A	3.6%

/12851
CSO: 5420/54

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CANADA

STUDIES ON LUNG PROBLEMS, WORK ENVIRONMENT DISCUSSED

Uranium Miners

Ottawa THE CITIZEN in English 30 Jan 86 p A4

[Unsigned article: "Lung Cancer Death Rate Jumps 57% for Miners"]

[Text] TORONTO (CP) — The incidence of lung cancer deaths in uranium miners leaped by 57 per cent between 1981 and 1984, figures from the Ontario Workers' Compensation Board show.

As of October 1984, 274 Ontario uranium miners had died from lung cancer. The number of deaths stood at 174 at the end of 1981, 119 at the end of 1977 and 81 in 1974.

Members of the United Steelworkers of America are concerned that the figures represent only the tip of the iceberg.

A study conducted by the Ontario Labor Ministry, the compensation board and the federal Atomic Energy Control Board said lung cancer deaths among uranium miners can be expected to peak around the year 2000.

"As lung cancer is a relatively rare disease at ages below 40 years, and the age-specific death rate rapidly increases in higher age groups, a substantial rise can be expected in the number of lung cancer cases" among uranium miners in the future, it said.

The study, which analysed the mortality of Ontario miners from 1955 to 1977, is tracking 50,201 full-time underground miners by the ore they mined. Almost 16,000 of them worked in uranium mines.

The number of lung cancer deaths among uranium miners was 81 per cent higher than among the general male population in Ontario.

However, the Steelworkers argue the study did not take into account the "healthy-worker-effect factor."

Homer Seguin, a Steelworkers official in Sudbury, said miners must undergo a rigorous medical examination before they are permitted to work underground. The industry rejects the weak and keeps the strong and fit, he said. "We don't make up a general population."

Ed Vance, health and safety chairman for Steelworkers Local 5762 in Elliot Lake, said in an interview the magnitude of the peril, predicted in stormy debates in Parliament and the Ontario legislature in the mid-1970s, is coming to pass.

"It's happening right now," he said. "We're dying at a rate of three a month, and predictions are that in the year 2000, it's going to hit its peak."

Ontario Labor Minister's View

Toronto THE GLOBE AND MAIL in English 31 Jan 86 p A4

[Article by Regina Hickl-Szabo: "Miners' Cancer Figures Disputed by Minister"]

[Text] Ontario Labor Minister William Wrye has disputed reports that the number of uranium miners in the province who have died of lung cancer has jumped by 57 per cent in recent years.

He was responding to reports of figures compiled by the Ontario Workers Compensation Board which show that lung cancer deaths among uranium miners between 1981 and 1984 shot up by 57 per cent.

"While we certainly have a deep concern over the numbers and they are unacceptably high, there have been other mines that have been added between one reporting period and the other so the increase, while intolerably high, is not at 57 per cent," he told the Legislature yesterday.

Mr. Wrye went on to assure the House that the Government takes the issue seriously and plans to increase its support for the Canadian Institute for Radiation Safety.

Later, the minister said outside the House that he would see what he could do about lowering the levels at which radiation exposure is deemed hazardous when he meets his federal counterpart in the near future.

"We'll want to take a very close look at that."

New Democratic Party Leader Bob Rae had grilled Mr. Wrye about what he intends to do about "this tragedy of historic proportions" to ensure that "people who are working underground in this province will not suffer intolerable kinds of conditions when they retire and have to leave work."

When he heard Mr. Wrye's response in the Legislature, he retorted:

"I do not know how the minister can give us this bureacratic gobbledegook when he is faced with those kinds of realities."

Lung cancer rates among uranium miners are almost double those of the general population, Mr. Rae told the House. Among gold miners, he said, the rates rise at least 30 per cent higher.

Members of the United Steelworkers of America are worried that miners are just seeing the tip of the iceberg.

A joint 1983 study by the Labor Ministry, the Atomic Energy Control Board of Canada and the WCB found that lung cancer deaths among uranium miners can be expected to peak around the year 2000.

Mr. Rae also raised the fact that more than half the survivors of lung cancer are not receiving compensation from the WCB, a matter first raised in news reports earlier this week.

Mr. Wrye replied that some of the cases of miners who were denied compensation will be re-opened at some point in the future.

"Certainly the (WCB's) corporate board will be advised to take a look at that," he to'd the House.

He assured members of the Legislature that "we are not going to be satisfied until we have made some much more impressive progress.

Gold Miners

Toronto THE GLOBE AND MAIL in English 7 Feb 86 pp A1, A5

[Article by Victor Malarek: "Death and Disease Among Gold Miners Spark Investigation"]

[Text] Scores of gold miners in Ontario have died, hundreds more have been seriously debilitated and a Labor Ministry team is trying to track down the cause or causes.

But while it continues its investigation, ailing miners and the widows of miners are being deprived of payments from the Workers Compensation Board.

The investigation was launched after a study called Mortality of Ontario Miners showed that more than 600 men who had mined gold in Timmins, Kirkland Lake and Fort William have died of lung cancer, stomach cancer, silicotuberculosis, silicosis and chronic interstitial pneumonia.

The study tracked 50,201 full-time underground miners from 1955 to 1977.

When the death toll is compared with that of Ontario's general male population, it suggests that a tragedy of considerable proportions is unfolding.

The fate of these miners, and of those who are expected to be stricken, is being likened to the continuing tragedy of the radioactive uranium mines of Elliot Lake and Bancroft, Ont., where 274 miners are known to have died of lung cancer.

Details of the epidemic are expected to be revealed in the report of the research team operating under the Ontario Ministry of Labor's occupational health and safety branch. It has been investigating the gold mines for almost three years and is analyzing mounds of data that may turn up the probable cause.

Officials with the United Steelworkers of America, which represents most miners in the province, say they are fed up with years of bureaucratic foot-dragging by the Ministry of Labor and the Workers Compensation Board in dealing with the health problems faced by Ontario miners.

Homer Seguin, regional representative for the Steelworkers in Sudbury, said the union wants the province to take immediate steps to prevent "the continuation of the excess mortalities."

"We are convinced the excess cancers are caused by a contaminated mine environment," he said.

Mr. Seguin said "substantial responsibility" for the high death rate among former gold miners rests with the Ontario and federal governments and their inadequate miners' health and safety legislation and enforcement.

The union is about to launch a "massive offensive" in Northern Ontario to get the mines cleaned up, he said.

A major thrust of that offensive will be aimed at the WCB and getting it to "compensate the victims and the widows the millions of dollars that are owed to hem."

No one argues that the high death rate is caused by something in the workplace, Mr. Seguin said.

"We know it is work-related and that means the survivors and widows are entitled to workers' compensation benefits. Yet the Government has had this study for three years and still the WCB continues to refuse to give our members the benefit of the doubt and compensate them.

"It's a damn shame and it's a demonstration of the Government's lack of heart to the victims and their failure to act fairly and responsibly."

Richard Murzin, a spokesman for the WCB, said the board is waiting for the results of the research team's study, likely to be completed in the early spring, before it makes a decision on the gold miners' claims.

He said that once the study has been reviewed by board specialists, the board will decide on whether to accept lung cancer and stomach

cancer in gold miners as a compensable occupational disease.

Mr. Murzin added that the other diseases — silicosis, silicotuberculosis and interstitial pneumonia are compensable industrial diseases in all miners.

William Wrye, Ontario's Labor Minister, was unavailable for comment.

However, Dr. Jan Muller, who carried out the mortality study, said he is currently wrapping up the second study for the Labor Ministry.

"What we are trying to determine is whether there is any link to occupational exposure to something in that mine environment and increased risk of disease," Dr. Muller said.

He said what he found in the gold mines during the first study "came as a complete surprise. We were not looking for it and we did not expect what we found either."

One of the surprises was that almost 300 gold and mixed ore miners died of lung cancer. The rate of these deaths was 45 per cent higher than in the general population.

"The increase by 93 deaths from this cause (lung cancer) is highly statistically significant," the report said, adding that "most likely . . . the entire increase . . . is due to gold mining."

The report noted that "no increased lung cancer risk could be demonstrated in part-time underground gold miners and underground mixed ore miners, strengthening the hypothesis that there is a true association between underground gold mining and increased lung cancer risk . . . ."

Another surprise was "a significantly increased stomach cancer rate." That disease took the lives of 60 gold miners — a death rate 48 per cent higher than that in the general population.

The study showed that the infective disease silicotuberculosis had taken the lives of more than 40 underground gold miners and 35 mixed ore miners working mines around Timmins, Kirkland Lake and Fort William.

The deaths from that disease are more than 6,000 per cent and 10,500 per cent higher, respectively, than is normally expected among Ontario males of similar ages.

In addition, the study showed that silicosis and chronic interstitial pneumonia had claimed the lives of 111 underground gold miners and 68 mixed ore miners. Respectively, those figures are about 1,600 per cent and 2,000 per cent higher than would normally be found in the general population.

The report of the study noted that nickel-copper miners, iron ore miners and other ore miners show "no increased risk of non-neoplastic (non-cancerous) lung disease," and concluded that "it can be considered most likely" that deaths from silicosis and chronic interstitial pneumonia and silicotuberculosis observed in gold and and mixed ore miners "can be actually attributed to gold mining only."

Mr. Seguin stressed that the chances of a gold miner dying of a respiratory disease are far greater when compared with the general population than the study indicates.

He said that using the general population to compare deaths among miners grossly distorts the magnitude and seriousness of the industrial health problems facing all miners.

What the study does not take into consideration is the "healthy worker effect." Mr. Seguin said miners must undergo a rigorous medical exam begore getting a certificate to work underground. "The industry rejects the weak and keeps the strong and fit. We don't make up the general population."

Dr. Muller acknowleged that Mr. Seguin's argument is valid. He said that the healthy worker effect was referred to in the study, which estimates that mortality rates in the mining population "usually range from 60 per cent to 90 per cent of that in the general population."

A healthy worker effect was observed in all groups of Ontario miners for most causes of death, particularly in diseases of the circulatory system. "Fewer deaths were actually observed than expected based on the Ontario population. This might well be partly due to the selection of healthy men into mining," the study said.

Sewage Plant Workers

Toronto THE TORONTO STAR in English 11 Feb 86 p A6

[Article by Darcy Henton: "Study Links Sewage Plant to Lung Illness in Workforce"]

[Text] An occupational health study at Ashbridge's Bay sewage treatment plant has identified a possible link between the plant's work environment and a lung problem discovered in some plant workers.

The study by Drs. J.R. Nethercott and D.L. Holness, obtained by The Star yesterday, shows workers in the Metro sewage plant's incinerator building have a lower lung capacity than workers in other occupations.

"This finding may point to damage of the lung tissue resulting from exposure to the working environment in the incinerator building," says the report, which is based on random tests on 50 plant workers last summer.

Noting a greater frequency of reporting "flu-like symptoms, cough, spitum production, wheezing and sore throats" by the sewage workers studied — compared to other groups of workers — the report recommends further study of both the workers and their environment.

It also recommends further investigation of workers in the plant's dewatering building, where workers reported experiencing "a recurring illness characterized by chills, fever, sore throat and cough."

Although the report shows no indication of polychlorinated biphenyls (pcb) contamination in levels above 20 parts per billion, it notes a high incidence of skin complaints.

"A review of preventive practises as they relate to skin protection should be undertaken," the report recommends.

Mark Stoeckle, chief shop steward of the Metro Toronto Civic Employees Union, said he's pleased that problem areas have been identified, but concerned about the speed at which they are being addressed.

/12851
CSO: 5420/54

CANADA

AIDS INCIDENCE, COUNTERMEASURES DISCUSSED

Notification Controversy

Vancouver THE SUN in English 23 Jan 86 p A3

[Article by Anne Mullens: "Calls to Donors Bother AIDS Group"]

[Text]

AIDS Vancouver and the Red Cross have clashed over Red Cross telephone calls to inform blood donors they have been exposed to the AIDS virus.

Two bisexual men have recently been told by telephone their blood tested positive for the virus. Both are married and have fathered children in the last year, a source said.

AIDS Vancouver director Bob Tivey said a phone call is an "inappropriate" way to break the news of a positive AIDS-virus test.

Neither man had told his wife of his previous bisexual contacts and both were extremely upset to hear that their wives and children now are at risk for developing acquired immune deficiency syndrome.

Tivey said: "We are concerned that when they (the donors) hang up the phone, they will not know what to do with that information. We don't want people to jump off balconies."

But Red Cross medical director Dr. Noel Buskard said the Red Cross believes the phone is the best way to maintain confidentiality.

"Our legal advice tells us a letter is much more dangerous as it can be read by someone else," he said.

The test results mean the men have been exposed to the virus and have developed antibodies to it. It is not known whether they are carriers of the virus, but medical officials say those testing positive should assume they are carriers.

It will not be known whether the men passed the virus on to their wives and through their wives to their newborn children until the family is tested, Buskard said.

Research has shown that about 10 per cent of the people testing positive eventually go on to develop AIDS, but recent findings indicate the percentage may be much higher, Tivey said.

"It may be as high as 40 per cent," Tivey said.

AIDS Vancouver believes that when blood tests positive, the Red Cross should ask the donor to come in to the Red Cross or the provincial test laboratory, or pass the information on to the individual's doctor, who would then ask the donor to come into the office.

But Buskard said: "If we call and say: 'We have found a problem with your blood and we'd like you to come in,'" the first thing the person is going to say is: 'Why? What's wrong? Did I test positive?' If we refuse to tell them they will stew all night, not know who to contact or talk to and that may more likely lead them to suicide."

Buskard said either he or his assistant, Dr. Penny Ballem, phone the people and spend "as much time as necessary" talking to them about the results. "We also tell them to call their doctor or AIDS Vancouver for further counselling," he said.

Since the B.C. Red Cross began screening blood in late September, Buskard said "half a dozen" people have been told they are positive for AIDS exposure.

Buskard said people considered high risks for AIDS — homosexual men, bisexual men, intravenous-drug users and women whose partners are bisexual or drug users — must not donate blood.

"We are upset that bisexual men are actually donating blood. They should not be surprised at the manner in which they were informed.

"These two individuals got what they deserved. It is hard to feel sorry for men who have put their wives and young children at risk."

Two Cases in Forces

Toronto THE TORONTO STAR in English 30 Jan 86 p A11

[Text] OTTAWA (CP) — Two cases of individuals with AIDS — one of whom died earlier this month — have been reported by the Canadian Forces.

"The other person is under a doctor's care," Maj. Ray Windsor of the national defence headquarters in Ottawa said yesterday.

The defence department, which has a policy prohibiting homosexuals from joining the armed forces, would not release the ages of the individuals nor where they were stationed.

AIDS (acquired immune deficiency syndrome) occurs most frequently in homosexual or bisexual men.

"The surgeon-general of the armed forces is . . . monitoring the situation and he'll be in close touch with health and welfare officials," Defence Minister Harvie Andre said yesterday.

A spokesman for the health department's Laboratory Centre for Disease Control said there is no need for panic.

"Simply joining the army is no reason to suggest you're going to get AIDS . . . nor any other bodily social contact," Dr. Alistair Clayton said.

The centre has received reports of 457 cases of AIDS in Canada so far, 217 of whom have died. About 75 per cent of the total number of cases have been homosexual or bisexual men.

Statement on Prison Screening

Ottawa THE CITIZEN in English 7 Feb 86 p A11

[Unsigned article: "Prisons Won't Screen Inmates for AIDS: Official"]

[Text] Federal prisoners will not be routinely screened for AIDS despite widespread concern when traces of the disease were found in an Alberta institution, a spokesman for Correctional Service Canada says.

"It's a very long process to have tests and it's very costly at the same time," Jacques Belanger said Thursday.

"Since we have a lot of movement — people coming in and going out — it would be very hard to track down."

Prisoners who appear to be suffering symptoms of Acquired Immunodeficiency Syndrome will be tested and active cases transferred to the prison's health care unit, Belanger said.

There are no active AIDS cases in any federal penitentiaries but a prisoner at the Bowden Institute in central Alberta has an AIDS-related complex and is suffering symptoms of the disease.

He has been transferred to the prison's health care unit although his condition will not necessarily develop further.

One other prisoner, serving time in an Ontario institution, had been classed as "sero-positive," meaning he was exposed to the AIDS virus at one time, but recent tests show he is not carrying the disease, said Belanger.

There have been 479 AIDS cases in Canada since the disease was detected and 228 of the victims have died.

Growing concern about AIDS in prisons is evidenced by a front-page article about the disease in the Correctional Service's in-house magazine, *Let's Talk*.

The article is part of an information program in the penitentiaries to reassure staff and inmates that the risk of contracting AIDS through casual contact is minimal or non-existent.

Doubling Every 10 Months

Toronto THE GLOBE AND MAIL in English 12 Feb 86 p A22

[Article by Susan Delacourt: "AIDS Rate up Sharply in Canada"]

[Text] The number of reported AIDS cases in Canada continues to double every 10 months, with almost 500 people in the country having contracted the usually fatal disease.

The latest figures from the Laboratory of Disease Control in Ottawa show that 45 more cases of acquired immune deficiency syndrome were reported last month, bringing the total in the country to 479.

Of those, about half have already died.

Without a cure in sight, the Department of Health and Welfare is making public education the first priority, encouraging more physicians to report AIDS cases and supporting increasing awareness among Canadians.

This kind of education "will go a long way" to help preventing the spread of the disease, said Kim Elslie, a health studies officer with the Department of Health and Welfare.

Ontario's public education program got under way yesterday as a provincially appointed panel introduced its fact sheets and ideas for workshops, speakers and seminars.

(According to the federal figures, more than 40 per cent of the reported AIDS cases have been in Ontario.)

Within the next couple of weeks, two fact sheets about AIDS will to appear in doctors' offices, hospitals, schools and health care units across the province.

Three workshops are also scheduled to be held by the end of March. After that, a speakers' service will be set up so that Ontario organizations can consult the panel to arrange public education.

Toronto Seminar

Toronto THE TORONTO STAR in English 13 Feb 86 p A15

[Article by Marilyn Dunlop: "Metro Has Fewer AIDS Cases Than Predicted, Seminar Hears]

[Text] The number of AIDS cases in Metro may not reach levels as high as predicted a year ago, a Wellesley Hospital medical specialist said yesterday.

Dr. Walter Pruzanski, director of immunology, said it was expected that by this time each of the University of Toronto teaching hospitals would be treating five or six patients with acquired immune deficiency syndrome.

"But we've hardly one or two at each hospital," he said.

The U of T teaching hospitals include all the major downtown hospitals and Sunnybrook Medical Centre.

Speaking at a seminar on sexually transmitted diseases, sponsored by Wellesley's department of family and community medicine, Pruzanski said analysis of the situation by doctors treating AIDS patients indicates the rate of increase is slowing down.

481 cases

Among 481 cases in Canada, 146 have occurred in Metro, said Dr. Evelyn Wallace of the Ontario health ministry. While the number of cases in Canada has doubled every eight months since AIDS was made a reportable disease in 1983, she said, "the vast amount of attention given AIDS is out of proporation to the the number of cases."

Wallace said the 187 Ontario patients have included only two women, one a nun from Haiti who died, and the other a woman from El Salvador. "There have been no

children patients in Ontario yet," she said.

Three of the patients injected drugs and were also homosexuals. It isn't possible to determine whether they got the AIDS virus from contaminated needles or sexual activity. However, the percentage of cases in drug users in the province has differed markedly from that seen in the United States where some 17 per cent of cases have involved street drug users.

Wallace said one person in Ontario contracted AIDS from a transfusion of whole blood and two were hemophiliacs given blood products required to control their bleeding. The remainder, 94 per cent, were homosexuals, she said, adding that half have died and none has lived longer than three years.

Public health doctors have begun to see a decline in the number of cases of gonorrhea, a disease that had increased sharply since the 1960s, Wallace said. "Fear of AIDS is resulting in a decrease in other sexually transmitted diseases," Wallace said.

However, she said, the previous upswing in the rate of gonorrhea must be considered "a failure of public health control." Among teenagers, 15 to 19, gonorrhea is more common in females than in males, she said. In older age groups it is more common in males.

More alarming, she said, is the appearance in Ontario of a strain of gonorrhea organism that is resistant to treatment by penicillin. The organism produces a substance that destroys penicillin. Until last year, such cases were all imported from abroad.

'Yuppie' disease

"Now it is possible to get it without leaving the province," Wallace said. So far this year 40 cases have been reported in Ontario — in Toronto and Ottawa. Most of the cases in Canada are in Ontario, she said.

Wallace also said chlamydia infections, which cause pelvic inflammatory disease, a major cause of infertility in women, "are the new Yuppie disease of the 1980s."

Women who postpone childbearing until they are in their 30s, and who have contracted an infection from the organism chlaymdia trachomatis by that time, can be devastated to discover they are infertile. About one in five women with the infection becomes infertile and the remainder risk tubal pregnancy (the fertilized egg grows in a fallopian tube, which ruptures).

Wallace said there has been a significant increase in such pregnancies in Canada. "When AIDS fades, more attention may be paid to chlamydia," she said.

Confidentiality Issue

Toronto THE GLOBE AND MAIL in English 14 Feb 86 p A12

[Article by Charlotte Montgomery: "Confidentiality of AIDS Records May Be Limited, Panel Told"]

[Text] OTTAWA

The confidentiality of medical records, which is less stringent than many Canadians believe, may have to be further limited if the spread of acquired immune deficiency syndrome is to be controlled, a lawyer who heads a study into the usually fatal disease told politicians yesterday.

People with AIDS and those who have developed antibodies to the disease should be reported to medical officers of health just as cases of syphilis and tuberculosis are reported, Tracy Tremayne-Lloyd told a House of Commons committee.

The Toronto lawyer, who heads a study of the legal implications of AIDS for the Canadian Bar Association's Ontario division, told the committee she believes a law requiring the reporting of such cases is essential. Unless doctors report AIDS cases and potential cases (those with antibodies) and unless medical officers of health use their power to follow up the contacts of AIDS victims, public confidence in the way authorities are dealing with the disease will be undermined.

Ms Tremayne-Lloyd told the committee that she does not personally favor waiting

until a person with antibodies develops AIDS (although not all do) to report the case. But, because of the discrimination faced by AIDS victims from frightened employers, co-workers, landlords and others, any law requiring reporting of cases would also have to be include specific legal protection from unfair treatment.

The lawyer said that her committee studying AIDS, which is due to produce a report and recommendations by April, has been told that thousands of Canadians "and no doubt hundreds of thousands" have been found to have developed antibodies to AIDS.

She said doctors do not feel bound to report those who have not developed the disease but have a chance of falling victim to it. The medical profession cannot be blamed when information from the Ontario Ministry of Health stresses the confidentiality of all dealings between doctor and patient.

"We're running into a problem of what is confidentiality . . . and when to breach it."

People have naive ideas of the confidentiality now surrounding medical records, she said, citing as an example the policing of medical charges for Ontario's medical insurance system. Doctors must submit accurate diagnostic information so the Government may audit billings and the Government may send inspectors to doctors' offices to examine and copy all records. These records would then become evidence if the doctor was taken to a tribunal in the event that his billings were challenged.

Patients, who may assume their written permission is needed to release information, would have no right to stop this procedure, Ms Tremayne-Lloyd told the committee. Although people involved in the process may be bound by rules of confidentiality, it should not be thought that confidentiality means that no one beyond the doctor would ever have access to medical information provided by or to a patient about his case.

The concept of mandatory testing for AIDS for any given group is a different matter from mandatory reporting of known medical information because it would mean "invading someone's person to get the information." But this is an issue that may have to be faced because some argue that in such situations as prisons, it is justified to require testing given the known homosexual activity among inmates.

AIDS is thought to be transmitted by a virus spread in semen and blood. Homosexual or bisexual men have been the primary victims but there have been rare cases in Canada of people contracting it through the transfusion of blood products.

The latest figures from Ottawa's Laboratory for Disease Control show that 470 people in the country have contracted the disease, about half of whom have already died. More than 40 per cent of the reported AIDS cases have been in Ontario.

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CANADA

VIRUS OUTBREAKS IN ONTARIO INSTITUTIONS REPORTED

Ottawa-Carleton Nursing Homes

Ottawa THE CITIZEN in English 30 Jan 86 p B7

[Unsigned article: "Outbreak of Contagious Norwalk Flu Virus Reported in a Number of Ottawa-Carleton Nursing Homes"]

[Text]
Residents and staff of some Ottawa-Carleton nursing homes have been hit by outbreaks of a highly contagious flu virus that causes severe bouts of vomiting and diarrhea.

One area institution was struck so hard by the illness, caused by the Norwalk virus, that it imposed a quarantine on itself for four weeks.

Lynda Welch, director of Extendicare Starwood nursing home in Nepean, said the institution just reopened its doors to visitors Monday.

About 110 of 192 residents, and 50 of 135 staff members caught the virus, said Welch. No one needed hospitalization.

In other homes, the virus, which can be particularly severe in elderly people and children, didn't spread so quickly.

The Norwalk virus brings on stomach cramps, diarrhea, nausea and vomiting lasting 24 to 48 hours.

Clarke Psychiatry Institute

Toronto THE TORONTO STAR in English 4 Feb 86 p A6

[Unsigned article: "Clarke Back in Operation Following Flu Epidemic"]

[Text] The Clarke Institute of Psychiatry, struck more than a week ago by an epidemic of a Norwalk-like flu, has been given a clean bill of health.

Spokesman Jennifer Fleming said the Toronto medical officer of health gave the facility the go-ahead to return services to normal by the end of the week.

In- and out-patient services and full visiting hours will resume today, Fleming said. But emergency services will be phased in this week while staffing returns to normal levels.

Fifty-six employees and 35 patients came down with the virus, which causes vomiting, diarrhea and intestinal cramps.

Riverdale Hospital

Toronto THE TORONTO STAR in English 12 Feb 86 p A6

[Unsigned article: "New Norwalk Cases Down at Riverdale"]

[Text] The outbreak of the flu-like Norwalk virus that has closed Riverdale Hospital to the public may be waning, hospital officials say. Only three new suspected cases showed up yesterday among patients, said Linda Madden, public relations officer.

This brings the total suspected cases to 61 for patients and 18 for staff. There have also been two confirmed cases among patients.

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CANADA

MEASLES OUTBREAKS IN BRITISH COLUMBIA SPUR VACCINATIONS

East Kootenay

Vancouver THE SUN in English 16 Jan 86 p A10

[Text] CRANBROOK — Outbreaks of rubella and red measles in the east Kootenay are being countered by mass vaccinations and warnings to young women, the area's public health officer said Wednesday.

Dr. Arnold Lowden said six of seven people with confirmed cases of rubella, or German measles, are Cranbrook secondary school students, while a janitor at Cranbrook's community college is the seventh case. All five people with confirmed cases of red measles are Creston preschoolers.

A special clinic to vaccinate against rubella opens in Cranbrook today while another clinic to vaccinate against measles opened Wednesday in Creston. Lowden forecast about 600 people will be vaccinated at the Cranbrook clinic alone.

At East Kootenay Community College, the president circulated a memo Wednesday advising teachers to warn young women of rubella's danger to the unborn. Those not vaccinated against the disease were encouraged to call their family doctor. Lowden said there has not been a serious rubella outbreak in thearea for more than 10 years.

Victoria Area

Vancouver THE WEEKEND SUN in English 25 Jan 86 p A15

[Text] VICTORIA — The measles epidemic in Greater Victoria is continuing to spread.

Capitol regional district medical health officer Dr. Brian Allen said another 43 cases were confirmed during the past week, bringing the total to about 160 since the outbreak began in the first week of January.

He said the incidents of new cases is averaging between 40 and 50 per week and is expected to last about another month.

Allen said the health unit is vaccinating students at all schools reporting two or more cases of measles.

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ONTARIO HOSPITAL STUDIES LINKUP WITH U.S. CORPORATION

Toronto THE TORONTO STAR in English 4 Feb 86 p A4

[Article by Dana Flavelle: "Hospital Vows Canadians First in U.S.-Paid Plan"]

[Text] LONDON, Ont. — Ontario residents would continue to receive priority treatment at University Hospital under a plan to attract more high-paying American patients, a hospital spokesman says.

Executive director Patrick Blewett gave the assurances at a press conference yesterday, following reports that the hospital is studying a joint expansion project with the Hospital Corporation of America.

"There's no way we could contemplate doing anything that would limit access to the hospital by Ontario residents," Blewett said. "The hospital is here principally for the care of Ontario residents. It was funded by the province, so our primary responsibility is to the Ontario resident."

If it came to a choice between performing surgery on a Canadian and an American patient, Blewett said, the Canadian would "obviously" get first priority.

Under the plan, the American firm would help finance an expansion of the hospital by paying for 50 "referral" beds for non-Canadian patients who could benefit from the London's expertise in neurosurgery and cardiology.

The rest of the expansion — up to 200 beds — would be for local residents.

Because University Hospital has expertise in certain areas, it already has 18 ministry-approved and financed beds for non-residents, Blewett noted. This would be an expanded referral program paid for by a private corporation, which would be repaid out of operating revenues.

The referral beds would be available to any out-of-country patients on an "as needed" basis, Blewett said. The Hospital Corporation of America has not asked for and does not want exclusive use of those beds, he said.

The plan would be a moneymaker for the London hospital — an estimated $10 million a year — because it can charge non-Canadian patients higher rates.

The program appeals to the Americans because, even at those higher rates, Canadian health-care costs are still cheaper, especially now that the dollar is 30 cents below the U.S. currency.

"One of the problems we have in the United States is extraordinarily high costs per patient stay," said Ron Trace, vice-president of Hospital Corporation of America, told the press conference. "Most employers, most insurance companies are looking for ways to reduce those costs."

Lower cost

A heart transplant, for example, is about half the cost in Canada, he said, adding that Americans will spend $400 billion this year on health care.

Because there is no universal government medicare, most Americans have private health

insurance and those plans are being stretched to the limit, he said.

Investing in the creation of additional beds for non-Canadian patients makes good business sense, he said.

In Toronto, the executive director of Toronto's District Health Council described the scheme as a new twist in a growing trend among Ontario hospitals to go the private sector for capital funding.

"The government's ability to fund them has not kept pace with increasing hospital costs," said Brent Chambers, noting that hospitals can wait up to eight years for the province to come up with the money.

Earl Myers, president of the Ontario Medical Association, said he approves of the plan.

"I'm all for it if they can increase their income," he said.

He said it's not much different from an Ontario resident going to the U.S. for treatment, noting that you can get a CAT scan faster in Buffalo than St. Catharines if you're willing to pay for it.

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CANADA

INCREASE IN MALARIA CASES IN ONTARIO DISCUSSED

Toronto THE TORONTO STAR in English 10 Feb 86 p D7

[Article by Robert Brehl: "Malaria Cases on the Increase Ministry Says "]

[Text] New Canadians who visit their Asian homelands without taking preventive drugs largely account for the continuing increase in malaria cases in Ontario, a medical expert says.

North York's cases more than tripled in one year, from nine in 1984 to 32 last year. The health ministry reports at least 147 cases across the province in 1985, up from 139 (including one death) in 1984.

Most new Canadians from such Third World countries as India, Pakistan and Afghanistan built up a partial immunity to malaria while growing up, said Dr. Jay Keystone, director of the tropical diseases unit at Toronto General Hospital.

"That i...munity will quite often disappear after several years in Canada," he said in an interview. "A lot of new Canadians go back for a visit, but never think about taking (anti-malarial) pills, and catch it because they've lost their immunity."

In 1972, there were only seven malaria cases in all of Canada. Cases surged briefly at the beginning of the 1980s, when many Viet Nam boat people entered Canada, a health ministry spokesman said.

Dr. Gordon Martin, North York's medical officer of health, told a recent board of health meeting that new Canadians must be warned about returning home without safeguarding themselves against malaria.

The disease is spread by mosquitos that bite humans who have malarial parasites in the blood stream. The mosquitos must be constantly reinfected to continue spreading the disease and, therefore, need a large population of infected humans to draw on.

"Malaria could be transmitted here if a mosquito happened to bite the person with the disease and then bit another person. But the chances are very slim," Keystone said.

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CANADA

SOURCE OF NORTHERN ONTARIO TB OUTBREAK TRACED

Toronto THE TORONTO STAR in English 4 Feb 86 p A2

[Text] ENGLEHART (CP-Special) — An elderly woman admitted into the Englehart and District Hospital between June and November last year has been identified as the source of a tuberculosis outbreak that infected more than 80 people.

The Timiskaming Health Unit originally thought a nurse spread the bacteria throughout the hospital, infecting 17 hospital staff and 68 patients. The number of patients who have contracted the bacteria has since risen to 83.

Tuberculosis, considered to be rare today, is a disease that destroys lung tissue. It can be contracted by breathing in microscopic droplets that carry the bacteria, or by drinking milk from a cow infected with active TB.

Hospital administrator John Armstrong said a report confirmed that an elderly woman was the cause of the outbreak.

The woman was admitted to the hospital in this community, about 120 kilometres (75 miles) southeast of Timmins, suffering from a lung ailment. Armstrong said she later died from the ailment and not TB.

The report was produced by Timiskaming's medical officer of health, Dr. Brian Primrose.

The confirmation yesterday ended a two-month investigation by the health unit, which had been searching for the origin of the bacteria.

The nurse first believed to have caused the outbreak has been treated with antibiotics and has returned to work along with 16 staff members who also contracted the bacteria. All are under observation by the health unit.

"The nurse was just an innocent bystander," said Primrose, adding the report presented to the hospital board Jan. 30 was a preliminary one.

The health unit screened more than 300 people who were admitted to the hospital between June and November, 1985.

Other health units in Vancouver, Sault Ste. Marie, Oshawa and Toronto have been trying to locate more than 50 people who managed to elude the screening.

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CSO: 5420/54

DENMARK

SEVERAL CASES OF LYME DISEASE REPORTED in 1985

Copenhagen AKTUELT in Danish 6 Feb 86 p 2

[Article by Ruth Northen]

[Text] Disease transmitted through bite of wood tick also common in this country.

In 1980, the U.S. Disease Control Center ascertained 280 cases of a disease which is caused by wood tick bites and which was given the name of the Lyme disease after the first place where the disease was ascertained in 1975. In 1984, 1,498 cases were reported, more than 5 times the original number of cases.

About 20 Cases Ascertained in Denmark in 1985

The reason is not that wood ticks might have become more aggressive or the disease more widespread but the fact that it is now known that certain symptoms show that it is a question of a certain infection which may be established by way of blood tests.

It is now believed that the disease also occurs in Denmark after it has been ascertained in a number of patients. Not least Klaus Hansen, a physician of the National Serum Institute, has made a contribution in this connection. In 1985 alone, he asertained about 20 cases of the disease. This may, however, be merely the tip of the iceberg.

It will only appear now. As of 1 February, physicians all over the country may submit samples (blood and synovial fluid) to the National Serum Institute if they suspect that a patient may have contracted the Lyme disease. This may be of special importance to pregnant women since the infection may have a teratogenetic effect.

Large Ring Around Bite

It is a special screw-shaped bacterium, a spirochaeta, that causes the symptoms. In certain respects, it resembles the syphilis bacterium. It lives inside the wood tick and may be transmitted to humans through the bites of wood ticks. Especially when walking in the woods, one may risk having a

wood tick drop from a tree and start sucking one's blood, especially in hairy areas. Most people attach no particular importance to wood tick bites (once the blood-filled tick has been removed). Many people who, subsequently, become ill may not even have noticed that they had been bitten by a wood tick.

A few days or weeks after the wood tick bite, a circular rash may develop around the area where the wood tick bite occurred, and, in some instances, it may become over 1 meter in diameter. If one does nothing about, it will usually heal by itself in the course of a few weeks, and there will be no further effects from the wood tick bite.

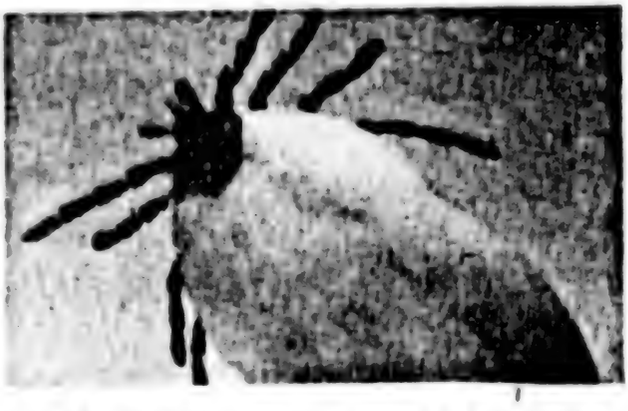
Second Stage

The infection, however, may, in some patients, have a second stage, where there may be heart or central nervous system symptoms. Irregular heart rhythm may occur because of infection of the heart muscle, or a burning sensation or minor cases of paralysis if the infection is located in the spinal marrow or the membrance of the brain. Another common symptom may be rheumatic pains, especially in the knees, a type of rheumatism which may become chronic.

Several other symptoms are now associated with the wood tick spirochaeta. It is known today, for example, that it may enter into the placenta of pregnant women and--though rarely--cause severe congenital deformity of the heart, which may lead to the death of the embryo.

Penicillin Curing Disease

Fortunately, it is known today that there is a cure for the disease in all of its manifestations and stages. Penicillin works both with regard to skin symptoms, rheumatism and inflammation of the heart and the brain; it should preferably be administered by way of injections. Also other antibiotics may help.



This is the way the wood tick looks

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FINLAND

RESEARCH ON AIDS CONTINUES AS NUMBER OF CASES INCREASE

Helsinki HELSINGIN SANOMAT in Finnish 30 Jan 86 p 9

[Article: "Aids Tests Had Few Visitors"]

[Text] More AIDS tests should be performed in our country than at present. This is the opinion of the expert doctors who emphasize that it is important for the health of the person who has been exposed to the HELV-III virus, as well as for the protection of his sexual partners. New cases in Finland are found at the rate of 2-3 a week, and in the future, as in other countries, the virus will be found increasingly more often also among heterosexuals.

A stable pair relationship is the best protection against infection, the health officials remind us. In the next few months the Central Medical Board will emphasize this point with a pamphlet being sent to every house, which appeals especially to the young. If one engages in casual relationships, condoms should always be used.

About 80 cases of HTLV-III virus, which exposes one to AIDS, have been detected in our country thus far. Of the 10 fallen ill, 5 have died, and about 30 have symptoms from their exposure. Dr Jukka Suni of Aurora Hospital says that according to these figures, we do not get to know soon enough about the people who have been exposed, but are still without symptoms.

"In Sweden, for example, the HTLV-III virus was detected among 1,000 individuals during the same period as our 100. Our population is only one-half the size, and the Finns and Swedes are in close interaction."

Results Feared

AIDS tests are feared apparently for the reason that a "positive" result means the same thing as a death sentence for many. But if the virus is detected at its very initial phase, there is a lot that can still be done.

According to Jukka Suni the most important thing at that point is the prevention of new HTLV-III infections. There are also ways to strengthen the body's natural immune systems and thus delay the onset of possible symptoms.

It is precisely the gradual appearance of the symptoms over a period of years which give the possibility for the spread of the disease. The carrier of the virus can unwittingly infect his sexual partners.

During the first year from the time of infection nearly all individuals are without symptoms, and during the second year signs of the virus show themselves among only 2 or 3 percent. However, during each of the following three years, 7 percent exhibit symptoms, so that by then we reach a quarter of those infected and the risk of illness doesn't end even then.

Because of the long incubation period of the disease, officials would like to urge all who have reason to suspect infection to take the tests. For example, at the Helsinki venereal diseases polyclinic, barely 1,000 have been tested. There has been no rush, although a blood test can generally be taken during the same day.

Credit to the Condom

The Central Medical Board will be sending information packets in the spring to every home with information on how to protect oneself from the virus causing AIDS. The most emphasized advice is to avoid casual sexual encounters. If one engages in them, a condom should always be used. If used correctly, it will protect or at least considerably reduce the risk.

Timo Rostila, epidemiologist for the City of Helsinki, says that the condom has a good reputation for preventing all kinds of sexually transmitted diseases, and the same is probably true for AIDS. The matter, of course, can't be verified by any controlled study in which one group would test the risk of infection without condoms.

According to Finnish experience, casual sexual relationships abroad, especially in Africa and in the Caribbean area, are especially dangerous for spreading AIDS. The proportion of heterosexuals among those infected will probably increase among us as new cases are detected.

"There is no cause for panic," says Jukka Suni. "We are, however, apparently moving toward an African form of the disease, which spreads by heterosexual intercourse and is thus both men's and women's disease."

Up to now about 80 percent of those in Finland verifiably infected have been homosexual men. Those transmitting the disease have also included 4 women, one of whom is an intravenous drug user. Three men have contracted the virus through blood transfusions or through a blood product required to treat hemophilia.

No New Infections Among Hemophiliac Patients

Blood transfusions and blood products do not appear to be nearly as significant a source of risk in Finland in transmitting the HTLV-III virus as in many other Western countries. According to a report completed last Tuesday by the blood services division of the Finnish Red Cross, none of the 133 individuals suffering from hemophilia has been found to have antibodies for the virus. Altogether there are fewer than 200 such patients in Finland, and during a comparable study performed 2 years ago, 2 cases of infection were found.

The chances of hemophiliacs becoming infected are considered greater than average because one of the preparations used in treatment requires blood from over a thousand donors. Dr Vesa Rasi, who has been directing the research, considers the results obtained quite good when compared to those of other countries.

The patients who participated in the research have used preparations containing blood samples which had not been tested in their entirety, as the Finnish Red Cross has now done from the beginning of the year. However, the preparation used most commonly in Finland requires the blood of only about 10 donors and any possible viruses in another medication are destroyed through pasteurization.

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GREECE

BRIEFS

AIDS STATISTICS--Thirteen cases of AIDS have so far been reported to the Ministry of Health and to the Greek AIDS Committee. This statement was made yesterday to newsmen by deputy minister of health G. Floros, who added that 10 of them have been fatal. [Excerpt] [Athens I KATHIMERINI in Greek 13 Feb 86 p 2]

CSO: 5400/2532

GUINEA-BISSAU

BRIEFS

MEASLES IN BIOMBO--The absence of a public health clinic in the Bissalanca section was a factor in the death of a child suffering from measles. The child was one of 25 found to have become ill during the epidemic in the Biombo region. A well-informed source in the village of Bissalanca told ANG that it has been several years since area health services have offered any vaccinations against diseases in that village. [Text] [Bissau NO PINTCHA in Portuguese 25 Jan 86 p 3] 12830/13045
CSO: 5400/72

HEALTH OFFICIALS CLOSELY WATCHING MALARIA SITUATION

Georgetown GUYANA CHRONICLE in English 23 Jan 86 p 5

[Text]

THE Malaria Eradication Division and Mosquito Control Service yesterday confirmed that a few cases of malaria have been reported in the interior but stressed that there was no reason for panic.

The cases, the Chronicle understands, have been reported largely in border areas and it is with this in mind that Guyana, Brazil and Venezuela have in recent times been co-ordinating their efforts to deal with the problem which has been raising its head in several parts of the world.

Principal Medical Officer in the Ministry of Health, Dr. Edgar London, who said there have been reports about a few cases, said the Mosquito Control Service was monitoring the situation and already had it under control in certain areas.

The difficult terrain in the hinterland was proving a major constraint for health officers as they travel to certain mines to carry out investigation and provide treatment if necessary.

Dr. London was happy to learn that the Guyana Gold and Diamond Miners Association had been calling on miners to observe health rules so that they could be better able to assist in the eradication battle.

In November last year, Health Minister Dr. Richard Van West-Charles, addressing the first technical meeting of a joint programme for the prevention and control of malaria in the region had noted that there must be a programme to sensitise the public about malaria.

"For us, everyone must be involved in the battle not only for the eradication but for the control of malaria," he had stressed.

/9317
CSO: 5440/051

GUYANA

BRIEFS

GASTRO IN BERBICE--Reports reaching the Mirror indicate that there has been an outbreak of gastroenteritis on the West Berbice. One child has already died under tragic circumstances with the parents of others expressing grave disquiet over the lack of proper guidelines and special treatment required for such cases, many of which require hospital care. [Excerpt] [Georgetown MIRROR in English 19 Jan 86 p 3] /9317

MEDICAL TRAINING NEEDS--Permanent Secretary at the Ministry of Health Claude Philadelphia has stated that for Guyana to attain health for all by the year 2000 we must ensure that intense training programme for our medical personnel are continued. The Permanent Secretary was speaking at the opening ceremony of a training programme for midwives, staff nurses, staff nurse/midwives, sisters and administrators of the Georgetown hospital yesterday at the Nurses Training Centre, Georgetown. "We must acquire adequate personnel to take care of our needs," the Permanent Secretary said, pointing out that Guyana today has one of the lowest population ratio of medical personnel and that the majority of the personnel is concentrated in the cities, leaving the regional areas with a low rate of doctors and nurses. A serious problem also, Cde Philadelphia stressed was that of migration of nurses adding that the Ministry will not allow nurses to use our system to learn and develop skills and then just leave for elsewhere. The Permanent Secretary said that the Ministry is trying to do all it can to make nurses happy and stay on the job. [Text] [Georgetown GUYANA CHRONICLE in English 29 Jan 86 p 5] /9317

CSO: 5440/051

INDIA

MEDICAL COUNCIL REPORTS INDIA FREE OF AIDS

New Delhi PATRIOT in English 18 Feb 86 p 5

[Text]

India is free from the dreaded Acquired Immuno-Deficiency Syndrome, commonly known as AIDS, reports UNI.

"No case of AIDS has been detected in any part of the country so far," Indian Council of Medical Research (ICMR) director V Ramalingaswamy told a news conference here today and added "I hope we can continue to remain in this happy position."

He said an ICMR task force, set up recently, had examined about 400 people in the high risk category and found all of them negative.

A surveillance machinery that would investigate high risk groups would fan out to important tourist spots and other places, including Goa, Kulu and Srinagar, he said.

Prof Ramalirgaswamy said a person from Kerala, who has refused entry into a Gulf country recently for suspected AIDS infection, was examined by the ICMR experts. Test proved that there was no clinical manifestation of the AIDS virus in him," he added.

Explaining the preventive measures the ICMR was considering, he said the task force had recommended establishment of a surveillance machinery to investigate and examine high-risk groups.

Two ICMR laboratories — the National Institute of Virology, Pune and Christian Medical College, Vellore — have been designated as AIDS reference laboratories and were undertaking sero-diagnosis of high risk subjects, he said.

Medical colleges were being alerted about the possible occurrence of AIDS among high risk groups and were advised to send sera from suspected patients to the reference laboratories, Prof Ramalingaswamy said.

/9317
CSO: 5450/0117

INDIA

BRIEFS

EXPOSURE TO FILARIASIS--Lucknow, Feb 14 (PTI)--The population exposed to the risk of filariasis in India had increased from 25 million in 1955 to 300 million in 1981, according to an estimate. Of these, 22 million were estimated to be the "microfilaraemic" carriers and 16 million had "clinico-patholigical" manifestations. The disease was endemic all over the country except for a few western, northern and far eastern states, says reports brought out by the Central Drug Research Institute (CDRI) on the occasion of second Asian congress of parasitology, in session here. The report says that surveys conducted in certain endemic villages in and around Lucknow showed that 17 percent of the population harbour microfilariae in the peripheral blood. The difference in the prevalence rate in the males and females was not statistically significant, it said. Moreover, the intensity of microfilaraemia appeared to be higher in the younger age group. The report further mentions that there was no proper drug for the treatment of filariasis in the country. [Excerpt] [New Delhi PATRIOT in English 15 Feb 86 p 8] /9317

LEPROSY STATISTICS--There are about 65,000 leprosy patients in the Greater Calcutta area, of whom about 40,000 are under treatment. According to figures available with the West Bengal Government's health department, the total number of estimated case of leprosy in the State would be around 584,000 the number in Calcutta being over 23,000. The figures revealed that the prevalence of the disease is the highest in Purulia, where 30 persons per 1,000 people are afflicted with it. The number of patients per 1,000 people in Bankura is 20, 15 each in Midnapore and Birbhum, 13 in Burdwan, 12 in Jalpaiguri and 10 in West Dinajpore, the rest of the districts having figures below 10. The figure in Calcutta and 24-Parganas is 7 per 1,000 people. [Excerpt] [Calcutta THE STATESMAN in English 28 Jan 86 p 3] /9317

CSO: 5450/0118

INDONESIA

CHOLERA, DIARRHEA DEATH TOLL

Jakarta ANTARA NEWS BULLETIN in English 14 Feb 86 p A8

[Text] Ujungpandang, Feb 14 (ANTARA)--As many as 1,444 people of South Sulawesi have died of cholera and diarrhea in the last five years. In 1985 the two diseases killed 152.

The head of the regional service for communicable disease eradication of the ministry of health, Dr A. Muin, has said as many as 308,854 cases of diarrhea and 144,804 cases of cholera have been found in the region since 1980.

The official attributed the cause of the diseases to the unhealthy environment of the region. The results of the examination on the samples of water from the region in the last two years was negative.

Besides cholera and diarrhea, Dr A. Muin found malaria, tbc, leprosy and dengue as major diseases in the region.

To curb the spread of the diseases the regional service has carried out steps such as distribution of medicine to the people in cooperation with the regional administration.

/9317
CSO: 5400/4355

GOVERNMENT ANNOUNCES CUTS IN HEALTH BOARD FUNDS

Dublin IRISH INDEPENDENT in English 1 Feb 86 p 1

[Article by Bernard Purcell]

[Text]

HEALTH MINISTER Barry Desmond shocked regional health boards for the second time in two days yesterday — savagely cutting their funding for 1986.

Massive cut-backs in the money used for day-to-day running of the health networks were announced.

Chief executive officers of the various boards, still reeling from the newspaper disclosure that eight hospitals are to be closed, were told of the cut-backs only yesterday, by post.

The South-Eastern Health Board gets £85.55 million—some £7 million less than last year's spending.

Total allocation to the boards this year is £832,645,000 including £58m for homes for mentally handicaped people.

The Department of Health also disclosed that a "certain amount" had been withheld from allocations towards eliminating 1984 and 1985 cost overruns on approved expenditure levels.

And the Irish Medical Organisation said members were astonished Mr. Desmond did not see fit to consult health boards and interested parties about the hospital closures.

Meanwhile, Labour Party administrative council member Joe Higgins declared Mr. Desmond's plans were in gross violation of party policies, as confirmed at conference last year, and said there should be an immediate move to end Coalition and the disgraceful role as axemen for Fine Gael.

Senator Timmy Conway, chairman of Kildare Co. Council, said he will raise closure of St. Dympna's, Carlow, at next meeting of Labour's parliamentary party, on Wednesday.

Closures of psychiatric hospitals will mean the loss of up to 300 nursing jobs. And two leading phychiatrists said it would lead to homelessness among the mentally ill.

/9317
CSO: 5440/052

IRELAND

GOVERNMENT URGED TO TAKE ACTION AGAINST 'SUPERBUG' IN HOSPITALS

Dublin SUNDAY PRESS in English 9 Feb 86 p 1

[Article by William Rocke]

[Text]

THE DEPARTMENT of Health should take action on an infectious superbug which has hit Irish hospitals and which is causing concern in hospitals in England, Australia and North America, according to a leading microbiologist in Dublin.

Dr. Conor Keane, a consultant microbiologist at St. James's Hospital, who is also Associate Professor in Clinical Microbiology in T.C.D., wants the Department to set up a proper monitoring system in our hospitals on the staphylococcus superbug which he says has now become a major problem.

The infection, which according to Dr. Keane can only be picked up in hospital, can strike in any area. Patients who have had surgery are particularly vulnerable. While emphasising that the staphylococcus outbreak here was not in the same proportion as in Melbourne, where people are now refusing to go into hospital to have wounds treated, Dr. Keane is emphatic that the danger signs are out here and that the Department of Health should take stronger action to combat it.

No Services

Dr Keane would like to see a Central Infection Unit set up with a proper monitoring system between hospitals. "Many of our hospitals have no isolation facilities and no backup services to combat infection. Each major hospital has an Infection Control Officer but the facilities to isolate infected patients are limited."

"Where patients are being transferred it is imperative that the receiving hospital be informed of possible infection by a patient so that isolation can take place and whole wards not have to be closed down."

On the BBC 2 *Horizon* programme last week viewers saw the chaos caused in Melbourne's largest hospital by the superbug the medical profession called the "Golden Staph" since it struck there in the mid-70s. The bug has proved immune to most established drugs but Melbourne waged war with old-fashioned methods like strenuous sterile procedures, ceaseless monitoring and by modifying hospital installations to make disinfection easier.

The programme pin-pointed other cities where the Golden Staph was known to be causing concern in hospitals — and Dublin and Liverpool were two of those mentioned.

CAME IN 70'S

Dr. Keane says the staphylococcus bug was relatively benign when it began to show in Ireland in the mid-70s. "Unfortunately it wasn't taken seriously enough by the medical people here and now it is creating enormous problems for us." It has caused many deaths in Australia and America, but it is difficult to know how many have died from the infection here as there is no central monitoring system in operation.

Dr. Alfie Walsh of the Department of Health says that all hospitals here are aware of the infection but that as far as the Department is concerned there is no raging outbreak.

/9317
CSO: 5440/052

IRELAND

FOOD POISONING DANGER FOUND AT HEALTH BOARD HOSPITALS

Dublin IRISH INDEPENDENT in English 30 Jan 86 p 3

[Article by Tom Reddy]

[Text]

PATIENTS in Health Board hospitals face severe food poisoning hygiene standards, it was claimed... yesterday.

Contaminataed food, dirty kitchens, cockroaches and infestations are common in many hospitals throughout the country, claimed the Irish Society of Food Hygiene Technology Association spokesman Seamus Kiely.

Food Hygiene regulations are enforced by Health Boards, and the results of occasional surveys by Health Board administered hospittls remains a secret, said Mr. Kiely.

"We want the surveys published so that it can be determined whether we need new regulations or a new policing system," he added.

"It is very common to find poor standards of hygiene and infestations in hospitals. The Health Boards monitor their own situation and have never published these results."

The Society's call for a new open approach to hospital and institutional hygiene etme after chairwoman Mrs. Ann Westby claimed that the State appeared to be immune to prosecution for hygiene lapses.

"While every effort was made to enforce the Food Hygiene Regulations and improve standards in the private sector it appears the State is immune to such regulations," she said, "Such places as hospitals, where hygiene was so important could not be prosecuted."

Mr. Kiely echoed her belief, saying hospital patients were particularly vulnerable in their weakened state.

"They are seriously at risk from food poisoning, and that could be fatal. These people are more at risk than the healthy," said Mr. Kiely, ,who ßis a lecturer in Environmentil Health.

Mr. Kiely, a spokesman for the private industry established pressure group, said last night that standards laid down in the Food Hygiene Regulations were only minimum standards.

/9317
CSO: 5440/052

ITALY

CENSIS EXAMINES NATIONAL HEALTH POLICY PROBLEMS

Rome L'UNITA in Italian 25 Jan 86 p 3

[Article by Nanni Riccobono]

[Text] Rome--According to CENSIS [Socio-economic Statistics Center], there is no health policy. Its annual report on health has been published. Included are data concerning lack of confidence on the part of the people regarding the question of health, the escalation of private hospital beds, inconsistency and injustice regarding health expenditure, new diseases connected with expansion, and the technological challenge.

The debate on health was bogged down in "abstractions and impotence," declares CENSIS, which yesterday published a summary of its annual social report on health. Besieged by contingent problems, as is the current doctors' protracted strike, the question of health from time to time is regarded by political and institutional forces as a fertile ground for "discussion," without their ever understanding that the challenge of the future requires specific attitudes and choices as a basis for action. Thus, the CENSIS study, which treats four aspects, offers a textual basis for an analysis of problems. It deals with the need, the workers, the technological challenge, and the interconnection of resources, action, and services.

It is an x-ray picture that immediately discloses worrisome facts; for example, lack of confidence--lack of confidence on the part of workers and of consumers regarding the national health service. Let us mention a single statistic: a sharp 30 percent annual increase in private health insurance. To this is added an opinion poll, according to which 50 percent of those interviewed consider the Italian post-reform health program to be worse than the pre-reform program, a circumstance which they attribute chiefly to excessive bureaucracy. Is this 50 percent of Italians right? The CENSIS report does not dwell on the technical aspects of the flight towards the private sector. It points out, however, that the percentage incidence of private beds of total hospital availability has undergone real escalation this past year: from 14.6 percent in 1981 to 17.8 percent in 1983. A table portrays the situation, region by region: in Lazio, private beds, compared with public beds, amount to 47 percent; the same is true of Basilicata, which is followed by Sicily, with 29.2 percent.

One of the first items on which CENSIS focuses its criticisms is the outlay for health, which in the gross national product is among the lowest in Europe, exceeded only by England. To this is added the inconsistency with which funds are appropriated, the injustice of the contributory system. CENSIS states that in 1984 medical contributions made by employed workers amounted to 11,189 billion, compared with 1,090 billion made by self-employed workers. Furthermore, if the total appropriation is broken down, one sees a considerable increase in medical and hospital expenditure. With respect to this question, the matter of hospitals, the study analyzes various aspects. First of all, specific mention is made of hospital expenditure, which amounts to 108.91 percent (from 1978 to 1981 and 52.37 percent of the total) and then of the non utilization of equipment (66 percent of availability is utilized). The second big problem is the non full inclusion of hospitals in the health reform. Except for some very rare exceptions, hospitals have not conformed to the principle of an internal reorganization in accordance with interdisciplinary and efficiency standards. Hospital stays are still very long, owing to a lack of the means for screening provided in the reform and not realized in this category. Furthermore, of the 9 and 1/2 million persons who are admitted to hospitals annually, about half a million contract infectious diseases of various types in the hospitals.

In the face of this schematic picture, rendered still more gloomy by the fact that technological challenge has not been accepted by the public system, to the great advantage of the private sector, there is a combination of varied and substantially greater needs. First of all, socio-demographic trends in our country have profoundly changed pathologies. While previously the most common diseases were the contagious ones, those resulting from poor nourishment or from hostile climatic factors, now pathological types connected with technological development are assuming more significance. It is a question of types that require strong advancement in prevention, which records a total increase of just 15 percent in the "service" administered by the public sector.

Another aspect, tied to increased longevity, has to do with cardio-circulatory illnesses, that often are characterized by mild symptoms that do not necessarily require hospitalization. For want of social assistance to the elderly, however, many old people end up by needlessly crowding into hospitals.

The public has become much more aware of prevention, the need for health care, and the need for medical information. The sales of 2 popular medical magazines have doubled in 2 years, and 40 percent of the clients who turn to a family doctor only want to "chat," to learn about this or that aspect of an illness or of a medicine, even though they are not in immediate need of this information.

Regarding the administrative structure of the health department: the CENSIS study states that the personnel employed by USL is characterized more by persons who have "political merit" than managerial talent. And it furnishes impressive statistics on the cultural training of this "political" personnel: presidents and vice presidents, health and administrative coordinators, and members of the management committee. Only about 35 percent have degrees (from Milan and Pavia); about 23 percent have only a simple license.

The table prepared by CENSIS presents a picture of the ever increasing substantial presence of the "private sector" in the hospital assistance system , especially in southern and in central Italy. The data are impressive for Lazio, where beds in private clinics equal 47 percent, compared with those in the public sector, and where in recent years (in absolute figures and in percentage) the "private sector" incidence has greatly increased. As can be seen in the last three columns of the table, it went from 29.9 percent in 1981 to 47.2 in 1983. Furthermore, no region is an exception: in all regions, in recent years, the number of beds in the private sector has been increasing notably--especially in the South. In Basilicata, as in Lazio, it has increased more than 15 points; in Puglia it has increased 4 points; in Calabria, more than 7 points; in Campania, more than 4 points. In absolute numbers, the record for private beds again goes to Lazio (1983 data) , with more than 15,000; followed by Lombardy, with 10,386; and by Campania, with 7,284 [sic; tables shows 7,274]; while the record for public beds goes to Lombardy, with 62,726; followed by Venetia, with 46,025; and by Emilia, with 32,802.

TABLE--BEDS: INCREASE IN BEDS IN PRIVATE CLINICS

	Public Beds (a)			Private Beds (a)			% of Beds of Priv. Tot.		
Regions	1981	1982	Pub. 1983	1981	1982	Priv. 1983	1981	1982	1983
N.W.ITALY	121,443	117,724	113,533	17,656	17,425	17,320	12.6	12.9	15.3
Piedmont	36,822	35,339	33,125	5,447	5,457	5,489	12.9	13.4	16.6
Aosta	605	621	621	-	-	-	-	-	-
Lombardy	65,490	63,975	62,726	10,725	10,498	10,386	14.1	14.1	16.6
Liguria	18,526	17,789	17,061	1,484	1,470	1,445	7.4	7.6	8.5
N.E.ITALY	108,891	103,515	100,167	11,627	11,603	11,595	9.6	10.1	11.6
Trentino Alto Adige	7,784	7,678	7,189	1,138	1,104	1,158	12.7	12.6	16.1
Venetia	51,142	47,889	46,025	3,720	3,719	3,715	6.8	7.2	8.1
Friuli Venezia Giulia	14,761	14,580	14,153	850	883	883	5.4	5.7	6.2
Emilia Romagna	35,204	33,368	32,802	5,910	5,907	5,839	14.4	15.0	17.8
CEN.ITALY	91,837	87,976	85,292	20,057	19,331	19,985	17.9	18.0	23.4
Tuscany	34,287	32,216	31,774	3,210	3,218	3,228	8.6	9.1	10.2
Umbria	6,951	6,439	6,460	265	265	265	3.6	4.0	4.1
Marches	16,428	15,789	15,052	1,981	1,258	1,382	10.7	7.4	9.2
Lazio	34,171	33,532	32,006	14,601	14,590	15,110	29.9	30.3	47.2
S.ITALY	132,724	129,905	127,273	28,200	27,663	26,911	17.5	17.6	21.1
Abruzzi	10,858	10,659	10,227	2,206	2,183	2,220	16.9	17.0	21.7
Molise	1,735	1,720	1,819	217	218	218	11.1	11.2	12.0
Campania	30,846	30,146	28,791	8,258	8,084	7,274	21.7	21.1	25.3
Puglia	30,753	30,553	29,952	6,941	6,685	6,581	18.4	18.0	22.0
Basilicata	3,430	3,458	3,286	1,560	1,660	1,560	31.2	32.4	47.5
Calabria	11,312	11,037	11,334	3,070	3,103	3,314	21.2	21.9	29.2
Sicily	33,082	31,801	31,315	4,031	4,223	4,153	10.2	11.7	13.3
Sardinia	10,708	10,531	10,549	1,647	1,507	1,591	13.3	12.5	15.1
ITALY	454,895	439,120	426,265	77,540	76,032	75,811	14.6	14.8	17.8

(a) The data includes general, specialized, and psychiatric hospitals.

8255
CSO: 5400/2525

ITALY

BRIEFS

CAMPAIGN AGAINST TB, SMOKING--The year 1986 is to be dedicated to the prevention of tuberculosis and smoking. The Ministry of Health has sent a circular on this subject to all the regions. According to this notice, Italy is considered by the World Health Organization (WHO) to have a low incidence of TB, although the disease has not been altogether eradicated. The same circular emphasizes the necessity of "discouraging smoking through information directed especially toward youth." Smoking is, in fact, "the principal cause of pulmonary tumors and of chronic bronchial and pneumonic pathology." From this fact, concludes the circular issued by Health Minister Degan, stems the decision "to intensify the effort against smoking, especially in the schools, and to fight related harmful causes such as environmental pollution and specific working conditions." Tomorrow afternoon, meanwhile, representatives of medical unions will meet with a governmental delegation in charge of solving the issue. [Text] [Rome LA REPUBBLICA in Italian 12/13 Jan 86 p 12] 13108/9274

CSO: 5100/2504

NEW ZEALAND

FIRST DEATH FROM DELTA HEPATITIS VIRUS

Auckland THE NEW ZEALAND HERALD in English 17 Feb 86 p 2

[Text] Medical experts have reported the first confirmed death in New Zealand from the delta hepatitis virus.

And they say the virus, although rare as yet, poses a potentially grave threat to New Zealand because of the high incidence of hepatitis B, particularly among Maori people.

Delta hepatitis can only occur in chronic carriers or those acutely infected with hepatitis B. There is no way of directly attacking the virus except by controlling hepatitis B.

In New Zealand, at any one time, as many as 10 percent of Maori children may be carrying the hepatitis B virus, with the highest prevalence in the northern half of the North Island.

Co-infection

While many chronic carriers of hepatitis B suffer no liver damage, the proportion that do rises dramatically with co-infection with the delta virus. Both viruses can result in death.

The first known victim of the delta virus in New Zealand was a 25-year-old musician, who died in Christchurch Hospital last year.

A study of the case by a team headed by Dr Martin Tobias of the National Health Institute is reported in the latest New Zealand Medical Journal.

The victim, who had a short history of intravenous heroin abuse and had shared needles, was admitted to Auckland Hospital in December 1984 and diagnosed as having acute hepatitis B.

Re-admission

He was discharged to convalesce at home after three days but was admitted to Christchurch Hospital 19 days later. He died 11 days after readmission.

Tests showed he had been infected with both delta and hepatitis B.

Dr Tobias said it was the first clear-cut acute case of co-infection with delta and hepatitis.

There were indications other people had been infected by the disease but there was still a very low prevalence of delta in New Zealand.

Tests on 85 drug addicts--a group in which the virus first appeared in Western Europe--showed that not one had antibodies to the delta virus.

However, because of the high level of hepatitis B, the situation was potentially more dangerous than in many overseas countries where delta had been found.

/9317
CSO: 5400/4326

NICARAGUA

BRIEFS

MALARIA INCIDENCE DISCUSSED--Every year, some 14,000 persons in Nicaragua are affected by malaria. This represents an average of four out of every 100,000 inhabitants, a Ministry of Health official stated today. This source explained that this disease has not reached epidemic proportions, despite the fact that the antimalaria program has been reduced in some war zones to which health personnel do not have access because of counterrevolutionary activities. The lack of foreign exchange for the purchase of the insecticides needed for fumigating homes and spraying the shores of Managua Lake has also limited the continuing antimalaria campaign being waged by the Ministry of Health. According to the reports of the director of the antimalaria program, Ramon Cruz, the western part of the country is most seriously affected, since the transmitting insect, the anopheles mosquito, has developed resistance because of the excessive use of the insecticides in the areas producing cotton, bananas and sugar cane. Malaria developed in the western part of the country as a result of the great influx of laborers coming from El Salvador and Honduras (in which countries there is a high incidence of this disease) in search of work during the harvest season. Currently the movement of peasants out of the war zones and the mobilization of thousands of young people for defense and production have facilitated the infection of individuals as a result of insect bites. In connection with an epidemiological outbreak of malaria in the municipality of Tipitapa, some 30 kilometers to the south of the capital, this official said that it was due to the lack of proper drainage and garbage collection systems, as well as the fact that this municipality is located in one of the basins of Managua Lake, where mosquitoes breed readily. In the early days of January, 70 cases of malaria were reported in that locality, but this minor outbreak has been controlled through emergency steps, including collective medication for 5 days with primaquine and chloroquine. The highest rate of mortality due to malaria occurred in Nicaragua in 1960, when there were 52 deaths for each 100,000 inhabitants. [Text] [Managua BARRICADA in Spanish 22 Jan 86 p 5] 5157

ANTITUBERCULOSIS CAMPAIGN--The detection of 656 new cases of tuberculosis in the region was reported during a press conference by Dr Karen Brudney, director of the Managua Regional Department of Tuberculosis. This doctor said that the disease caused by the tuberculosis microbacterium is curable, and that the problem encountered is the constant fear of the people of learning what ails them. Another difficulty has its origins in the fact that the treatment takes a long time. While patients need to pursue it daily for a

complete year, they tend to abandon it when they feel a little better. This happens in the majority of cases after a month of therapy, when patients see that their cough and fever are disappearing and that they are gaining weight. They then think they need no more medication, "but they do not realize that the disease still remains in their lungs," the doctor added. According to Dr Brudney, this problem is common to all diseases, and not just tuberculosis. For this reason the goal established for the year 1986 is improved education. The symptoms of this disease include a cough, which, if it lasts more than 2 or 3 weeks, should be checked at a health center, daily fever, night sweats and loss of weight. Diagnosis is easily accomplished simply by examining sputum under a microscope at any health center, to which specimens can be sent at any time of day. [Text] [Managua LA PRENSA in Spanish 19 Jan 96 p 5]

5157
CSO: 5400/2040

NIGERIA

BRIEFS

MEASLE DEATHS IN PLATEAU--Twenty-nine children between the ages of one - six years have died within two weeks in an outbreak of measles in two local government areas of Plateau State. The affected areas were Adogi, Garo, Agyaragun and Avikiyu villages in Lafia Local Government where 12 children died and Shinakai and Kalam villages in Shendam Local Government. Report from the area described the outbreak of the disease as worst of its kind in recent time. The District Head of Doro in Shendam Local Government, Mr Albert Tiolom said his subjects were now living in fear as the disease could spread to his district and particularly as health clinics in the area lacked anti-measles vaccine. [By Mike Reis] [Excerpt] [Kaduna NEW NIGERIAN in English 14 Feb 86 p 24] /12851

MEASLES OUTBREAK IN SOKOTO--Twenty people were said to have died while 500 others were treated, following an outbreak of measles in the Yabo Local Government area of Sokoto State between November last year and February this year, the state commissioner for health Hajiya Fatima Balaraba Ibrahim, said in Sokoto. Hajiya Fatima said that other areas affected by the disease included Bunza, Talatan Mafara, Isa and Gusau local government areas, adding that the situation was under control. She said that the affected areas were those not fully covered by the EPI and expressed the hope that by the time the whole state was covered, outbreaks of measles would be brought to the barest minimum. [Text] [Kano THE TRIUMPH in English 17 Feb 86 p 7] /12851

CSO: 5400/84

NORWAY

PHYSICIAN GIVES OVERVIEW OF AIDS SITUATION IN COUNTRY

Oslo ARBEIDERBLADET in Norwegian 8 Jan 86 p 9

[Article by Stig Grimelid: "350 Will Get AIDS by 1989"]

[Text] Nine of 17 registered AIDS-victims in Norway are dead. And the disease will spread widely in the coming years. Based on international experience there will be 350 AIDS-cases in Norway at the end of 1988. There is reason to believe that 175 of these will be dead at that time.

Homosexual and bisexual men continue to be the largest risk group in Norway, just like in most other countries where AIDS has been confirmed. Fifteen of the 17 in whom AIDS has been confirmed in Norway are homosexuals or bisexuals. One is a hemophiliac while the last one is an intravenous drug addict.

"Even if homosexual and bisexual men continue to be the majority of the AIDS patients in Norway, we believe there is reason to fear a rapid increase in the disease among intravenous drug addicts," says assistant chief physician Stig Froland. He is one of Norway's foremost AIDS experts.

One and a Half Million

Froland says that there is reason to believe that the spread of the disease in Norway will follow the pattern we know from other countries. This is to say that the number of AIDS patients will double every eighteen months.

"We believe that it is unjustified to make prognoses which reach many years into the future. Therefore we contented us with making prognoses until the end of 1988. From these prognoses we can calculate that there will be 350 AIDS victims in Norway. Using the same international calculations as a basis 175 of these patients will be dead," says Froland.

"The treatment of an AIDS patient costs the Norwegian health system somewhere between one and one and a half million kroner," says Froland. This figure includes everything, from when the disease is confirmed until the patient's death.

The Oslo Area

"The enormous expenditures from the health budget will hit primarily hospitals and other health services in the Oslo area. We can say that since we know

that AIDS is a large city phenomenon. And the cases we have and had of AIDS in Norway show that this is correct," says assistant chief physician Froland.

Froland believes that now the politicians need to take the disease seriously. He believes that funds must be appropriated specifically for AIDS. Not only for treatment of those who get the disease, but also for research intended to fight the terrible disease.

Stage Two

"For the time being the efforts in Norway have been concentrated around information about AIDS, how the disease spreads and who is in the risk groups. Now it is important that the efforts are directed to what I call stage two; i.e. appropriations for the treatment of those who have the disease and especially AIDS-connected research," says Froland.

"We cannot leave such research to experts in other countries. I believe that in the course of a five-year period it will be possible to start treatment of the disease. To be able to do that in Norway requires that we have participated in the research," says Froland.

No Money

As of today the government has not appropriated any money for larger projects within the AIDS research. The only funds which have been appropriated have come from private organizations. Forland tells that the Norwegian Research Council for Science and the Humanities (NAVF) has for the first time appropriated a stipend for AIDS research.

"This is naturally positive, but the stipend is only for one person. If we are to get an effective research in AIDS in Norway we need many more funds. In my opinion it is absolutely necessary that the politicians realize the importance of this. With the spread which we can expect in the coming years, we must receive additional funds for research as early as this year," Froland claims.

Rational View

Froland explains that he does not want to exaggerate the fear of AIDS. "I myself advocate a rational, balanced view of the disease and the danger of its spreading. The prognoses we use as a basis are one year old. Already at the end of 1985 we can state that the prognoses are correct.

Therefore I feel sure that the extent of AIDS will become so large that room must be found in the health budget for special appropriations. If this does not happen I fear that things will start to fall apart," says Froland.

12831
CSO: 5400/2522

PORTUGAL

HEALTH STATISTICS SHOW TUBERCULOSIS ON RISE

Lisbon DIARIO DE NOTICIAS in Portuguese 15 Jan 86 p 13

[Text] In 1984, according to the most recent health statistics, there were 6,908 new tuberculosis cases reported in Portugal.

The National Statistics Institute (INE) reported that the Beja, Lisbon, and Faro districts had the highest tuberculosis-related mortality rate. However, there was a slight decline from 1983 figures.

Pulmonary tuberculosis, the most common form of this disease, represents 4,152 of all the known cases in Portugal. This is followed by pleural and bronchial tuberculosis with 1,032 new cases, 963 cases represent tuberculosis localized in other tissues, and 761 cases are of primary tuberculosis.

The INE also reported a greater general incidence of tuberculosis among men who are 15 and older while most of the primary tuberculosis cases were among females who are less than 15 years old.

The figures for 1984 also show many incidences of brucellosis, or Malta fever. This disease is included among the zoonoses, diseases transmitted by animals.

There were 715 new cases of brucellosis reported that year in Portugal. This represents a significant increase from the 576 new cases reported in 1983.

The districts with the highest incidence of brucellosis are Braganca, 146 new cases, Portalegre, 98, and Lisbon, 88.

According to the statistics, of the 27 diseases requiring mandatory reporting in Portugal, tuberculosis and brucellosis remain public health problems.

Data on diseases requiring mandatory reporting is not fully reliable since, according to a source at the Ministry of Health, "few doctors report them".

For example, if we rely on the statistics, there are practically no venereal diseases in Portugal.

The primary cause of death in 1984 resulted from cerebrovascular diseases (24,201 deaths). This was followed by heart diseases (15,811 deaths) and malignant tumors (15,656 deaths). These three types of diseases were respectively responsible for 25, 16.3 and 16.1 percent of all deaths.

The INE reported that accidents remain the primary cause of death among the male population aged 15 to 34. It also reported 1,195 suicides and homicides committed during 1984 in Portugal.

9935/9738
CSO: 5400/2521

PORTUGAL

BRIEFS

AIDS STATISTICS--There are 21 confirmed AIDS (Acquired Immune Deficiency Syndrome) cases in Portugal and Prof Carneiro de Moura projects that there will be an increase of about 30 cases per year. "The low number of AIDS patients provides us with ideal conditions to treat them well and to take adequate preventive measures," declared Dr Carneiro de Moura, a professor at the School of Medicine. He explained that, of the 21 confirmed AIDS cases reported up to 31 December 1985, there is 1 woman and 66 percent of the others are homosexuals. "There are no drug addicts in the Portuguese group. There is only one hemophiliac. As a matter of fact, the majority of these patients are male homosexuals and one only is heterosexual," Dr Carneiro de Moura told the ANOP [Portuguese News Agency]. He added that there was an additional AIDS case involving a child who is less than 3 years old. The child, in effect the 22nd case, got the disease when he received a blood transfusion. Dr Carneiro de Moura underscored the need for screening blood used in transfusion. [Text] [Lisbon DIARIO DE NOTICIAS in Portuguese 23 Jan 86 p 28] 9935

/12951
CSO: 5400/2523

BRIEFS

CHOLERA OUTBREAKS IN REFUGEE CAMPS--Nairobi, 24 Feb--A team of local and foreign doctors has been rushed to northwest Somalia to fight a cholera outbreak in refugee camps. A large number of the refugees are reported to have died from the disease which broke out early this month, and as many as 3,000 refugees have been found to be suffering from cholera. In an article appearing in AL-AFRICA PRESS SERVICE, APS news bulletin, a Somali Government official, when contacted for comment, said that the two camps in northwest Togowagararh and Ganodb have been badly affected. He said that local and foreign doctors were working round the clock to prevent the disease from spreading to other camps. This is not the first time cholera has terrorized refugee camps, the article notes. Last year the disease kil ed a large number of refugees in the central-northwest and southwestern camps. The article continues that although the figures have not been revealed, hundreds of refugees have died in Ganed, Hargeysa, Bokona, and Jalaqusi towns. Overcrowding, poor nutrition, and most especially the lack of clean and adequate water have been blamed for the current outbreak of cholera in the camps. An official count put the death toll at 1,162 with 6,210 being treated. Most camps harbor more than 25,000 people, a number in excess of the facilities and food available, concludes the article. [Text] [Nairobi KNA in English 1730 GMT 24 Feb 86] /9365

CSO: 5400/81

INCREASE IN FUNDS EARMARKED FOR HEALTH IN NORTHERN IRELAND

Belfast NEWS LETTER in English 18 Feb 86 p 5

[Text]

THE GOVERNMENT yesterday announced a £28.4 million increase in health and personal social services spending in Northern Ireland for 1986-87.

It will mean more money for the development of paediatric cardiology services, renal services, and cervical screening services.

Money will also be earmarked for major prevention campaigns aimed at reducing coronary heart disease and the spread of AIDS.

Mr John Simpson, chairman of the Eastern Health Board, said the extra cash being offered was £5 million less than would be required to meet the modest operational plan submitted to the department.

He said another pruning operation would have to be mounted to claw back resources from existing services to finance planned projects including those in the Tower Block of Belfast City Hospital.

Mr Simpson welcomed the announcement of financial help for the specialised services but this also was less than the board had hoped for.

The extra £28.4 million is to be provided to cover this year's phased pay settlements, and pay and price increases in the next financial year. In addition there will be a further overall increase of 0.5 per cent to help fund urgent improvements in services.

In announcing the financial allocations for 1986/87 to the Health and Social Services Boards, Minister Richard Needham said:

"In addition the allocations will do much to improve renal services by funding night shift arrangements for dialysis, by assisting the development of continuous ambulatory peritoneal dialysis, and by allowing for the commissioning of special facilities for renal patients in the Belfast City Hospital.

/9317
CSO: 5440/053

BRIEFS

CATTLE DISEASE EPIDEMIC--About 500 heads of cattle died of various diseases that have broken out in an epidemic form in Amtali, Patharghata, Bamna, Betagi, Barguna Sadar and the adjacent upazilas of Kathalia and Mathbaria during last one month. It is learnt that the cattle attacked with 'Tarka' 'Badla' and 'Galafaso' died before the news reached the animal husbandry office. Some of the cattle died after pushing some injection, it is alleged. When contacted, one of the Animal Husbandry Department said field workers had been working in the affected areas but they could not take effective measures due to lack of medicines in the stock. [Text] [Dhaka THE NEW NATION in English 21 Jan 86 p 2] /13104

MORE CATTLE DEATHS--Cattle disease have broken out in an epidemic form in different areas under Tarail Upazila. It is learnt that the unidentified disease took a toll of about 150 cattleheads in last one month in the upazila. The affected areas include Sekander Nagar, Gayeshpur, Digadair, Rahcia, Bhadera, Jawai, Rawti and Surrounding villages. According to a report about 50 cattleheads died in Rahela, Rauti Bhadera and Jawar in a fortnight. One farmer from Digdail alleged that no adequate medicines were available at the upazila veterinary hospital and the animals are dying virtually without any treatment. [Text] [Dhaka THE BANGLADESH TIMES in English 18 Jan 86 p 2] /13104

CSO: 5450/0113

CANADA

BEAVERS NEAR KILLARNEY FOUND TO CARRY TULAREMIA VIRUS

Toronto THE TORONTO STAR in English 14 Feb 86 p A14

[Article by Don Umpherson: "Sudbury Trappers Face Tests for Virus Carried by Animals"]

[Text] KILLARNEY — Campers and canoeists vacationing in the nearby La Cloche Mountain area may be exposed to a dangerous virus carried by the local beaver population, biologists fear.

The disease — Tularemia — has been diagnosed in several trappers who handled infected beaver carcasses on trap lines bordering Killarney wilderness park, said Gerry Haarmeyer, a wildlife management officer with the natural resources ministry in Sudbury.

Killarney wilderness park is about 113 kilometres (70 miles) southwest of Sudbury.

An autopsy is also being conducted on a beaver found dead from unknown causes at the mouth of the river in nearby Georgian Bay.

Health units at Sudbury and Killarney, Laurentian and Guelph Universities and the ministry are conducting a study to probe the extent of the disease, not previously documented in the Sudbury district.

Several hundred area trappers in the district have been asked to undergo a blood test to determine if they have contracted the virus, which can be transmitted through handling infected animals, drinking contaminated water, swimming or having water come in contact with open cuts.

Though rarely fatal, the disease produces flu-like symptoms — once called "Trapper's Fever" — and has been known to cause miscarriages in women and a type of blood poisoning that can be lethal, according to Laurentian University biologist Frank Mallory.

Mallory said health officials are studying the virus because "Killarney Park is used by a great number of campers and canoers. The goal of the study is to find out if there is a health problem."

Ministry statistics indicate that in 1984 about 5,000 campers used the interior of the park, which consists mainly of canoe routes, while about 10,000 used a campground at George Lake.

/12851
CSO: 5420/55

COLOMBIA

RESURGENCE OF FOOT-AND-MOUTH DISEASE LEADS TO MILK SHORTAGE

Bogota EL ESPECTADOR in Spanish 28 Dec 85 p 11-A

[Article by Raul Osorio Vargas: "Hoof and Mouth Disease Reappears in Sopo Area"]

[Text] Cattle ranchers have warned that despite the 90 percent vaccination campaign, after the Analac Company has called for freeing the price of milk, and foreign scientists have come to Colombia to endorse the government's plans for controlling the disease, the A-Sabana/85 virus has reappeared in the Sopo area. Meanwhile, the government has issued a warning regarding a possible shortage of milk at the beginning of 1986 in the plains area around Bogota.

Jairo Arias Puerta, the manager of Analac, the National Association of Milk Producers, in an interview with a representative of EL ESPECTADOR, confirmed that the A-Sabana/85 virus has reappeared on a ranch in the Sopo area where the cattle had already been vaccinated. He declared that as a result of the new outbreak five animals have died.

The director of the association stated that despite the vaccination campaign sponsored by Analac, the VECOL and the ICA, the disease has broken out again. At the same time he denounced rumors that are circulating to the effect that so-called cattle dealers deliberately have spread about meat from cattle infected by the disease in order to introduce it in the Bogota area and so buy up for a trifle cattle with a high commercial value.

Arias Puerta indicated that at the most recent meeting of its board of directors Analac confirmed that, with regard to sanitary policy, it will take emergency action when outbreaks take place. He added that this attitude makes it impossible to respond properly to the expansion and seriousness of this scourge.

He stated: "We consider that the limited results of the control program, the irrefutable fact of the reappearance of the disease among cattle which have already gone through the vaccination cycle, and the consequent skepticism which has been generated regarding the effectiveness of the measures taken

make it worthwhile to bring into this country scientists from the Panaftosa organization to approve the plans that have been made and to assist in the application of the most up to date measures available which have been developed for the health authorities."

He said that the biological risk, which the scientists are aware of, cannot be understood by cattle ranchers who see their herds disappearing after they have done everything which the standards require of them.

Shortage of Milk

Raul Londono Escobar, the manager of VECOL, warned of "a possible shortage of milk at the beginning of 1986 in the plains around Bogota, as a consequence of the renewed outbreaks of hoof and mouth disease in cattle herds, in addition to the frosts and the volcanic ashes which have resulted in a considerable deterioration in pasture grounds on the high plateau area in the Departments of Cundinamarca and Boyaca."

The official explained that the outbreaks of hoof and mouth disease are continuing due to the large concentrations of infected cattle within and outside the area affected, clandestine sales of cattle already suffering from the disease, and the inadequate application of proper sanitary measures on the cattle ranches.

Emergency Plan

Jairo Arias Puerta, the manager of Analac, reiterated the proposal to set up an "Emergency Plan to Fight Against Hoof and Mouth Disease" and stated that, in effect, the difficulties described by cattle ranchers in different areas are real enough.

He stated that the association had presented a proposal to Roberto Mejia Caicedo, the minister of agriculture, regarding the adoption of measures to stimulate the milk sub sector.

He said that the principal elements of milk policy should be taken into consideration in the following order: a change in tax policy, freeing milk prices, a basic restructuring of the industry, and the establishment of a national milk committee.

He pointed out that, with regard to a change in tax policy, Analac recognizes that it is not exclusively up to the Ministry of Agriculture to change the tax system and budgetary policies. However, he asked that an effort be made by that ministry to prepare a draft tax law appropriate to conditions in the countryside.

Conclusions

Finally, he recalled that the conclusions of the various discussions that have been held on hoof and mouth disease under the auspices of Analac may be summarized as follows:

--The establishment of a plan of action for the areas periodically most exposed to this disease. In the particular case of the plains around Bogota precise dates should be determined for vaccination, with total coverage in some limited areas.

--A change in the health regulations in effect, applying much more severe controls on vaccination, concentrations of cattle, and animal fairs, expositions, and commercial sales.

--Integrating the efforts of different national, departmental, and municipal services which have a role to play regarding the health aspects of the problem.

--Applying a health plan, first of all on the Atlantic Coast and in the river basins devoted to the dairy industry in the rest of the country, not only because of the social and economic impact of dairy products but because of the political impact which this disease has in areas surrounding departmental capitals.

5170
CSO: 5400/2027

HONG KONG

BRIEFS

PIGEON KILLER DISEASE--Hundreds of pigeons are dying every day in Hongkong and some 5,000 pigeons are believed to be suffering from diseases -- the largest number of cases ever reported to the Agriculture and Fisheries Department. The recent cold spells and the inexperience of pigeon-farmers are being blamed for the outbreak of three common, highly infectious diseases -- New Castle virus, parasitic infection and salmonella infection. A Senior Veterinary Officer of the department, Dr Norman Cheng, told THE STANDARD yesterday that consumers need not worry, as in six of every 10 pigeon deaths investigated, the cause was confirmed as New Castle disease, which does not affect human beings, only birds. Dr Cheng said most cases were reported at Yuen Long and Kam Tin, where 80 percent of Hongkong's 500 pigeon farms are located. Dr Cheng said the department has always advised farmers to give antibiotics to pigeons with diseases to prevent secondary infections. Vaccinations and separation are advised for all pigeons and chickens without diseases. [Excerpt] [Hong Kong HONGKONG STANDARD in English 24 Jan 86 p 7] /12851

CSO: 5450/0116

NIGERIA

RINDERPEST UNDER CONTROL, BUFFER ZONE CREATED

Kaduna NEW NIGERIAN in English 21 Feb 86 pp 1, 15

[Article by Sani Haruna]

[Text] Rinderpest, the deadly disease which killed thousands of cattle in the past few years, is now not only under control but might be completely wiped out.

Apart from strong measures taken to control it, a 16-kilometre buffer zone along our borders has been created to provide medical protection to our livestock against contagious effect from neighbouring countries.

The Buffer zone Co-ordinator of the National Rinderpest Task Force, Dr S.A. Okoduwa, told the NEW NIGERIAN in Kano yesterday that in 1983 there were 189 rinderpest outbreaks. 334 in 1984 and only 34 last year. He said so far there has not been a single case of rinderpest outbreak this year.

He said at earlier meetings of the Lake Chad Basin Commission technical sub-committee, an action plan was initiated in 1984 by the National Rinderpest Task Force on creation of the buffer zones.

The coordinator said, under this approach, each of the member nations, Nigeria, Chad, Niger and Cameroun, was to carry out extensive vaccination campaign to ensure solid immunity of cattle within 16 kilometers of its borders.

He said each country's vaccination team was to be guaranteed access to vaccinate cattle as far as the 16 kilometers from its border into other countries.

Dr Okoduwa said efforts had been made this year to enhance effective international co-operation towards the control of the disease both at borders in particular and in Nigeria.

He said massive vaccination campaigns, in border locations were to be synchronised with the same in other countries, adding that animals not vaccinated across the border were to be quarantined and vaccinated.

/12851
CSO: 5400/84

SOUTH AFRICA

RABIES FLARES ALONG NATAL COAST

Johannesburg THE CITIZEN in English 25 Feb 86, p 14

[Text] DURBAN. — An Amanzimtoti vet was bitten by a rabid dog this week and four animals with the disease were distroyed as the rabies flared up again along the Natal coast.

The State Veterinarian for Natal, Dr Bill Posthumus, and Durban's state veterinarian, Dr Robin Thorogood, confirmed the three positive rabies cases at Umzinto, Port Shepstone and the Phoenix/Stanger area this week.

Dr Posthumus said a rabid stray dog went wild on a Port Shepstone farm causing havoc as it chased the farmer's dogs and geese it finally fell into the swimming pool.

Nobody was bitten in this instance and the dog was destroyed.

However, a dog belonging to an Indian family in Umzinto was taken to a vet in Amanzimtoti on Tuesday and bit the vet before it was destroyed.

The name of the vet could not be disclosed but he was given the appropriate anti-rabies treatment.

The third case, which occurred near Phoenix was a puppy. The pup did not bite a human but apparently bit the neighbour's dog, which also had to be put down.

Dr Posthumus said: "We are just going to have to live with rabied and this week's incidents show how widespread it is. Three in a week is not particularly frightening but it is serious and disturbing because it shows that after seven years of trying to eradicate rabies we are still not on top of it.

"It is frustrating —even after all the publicity and our warnings that if people do not have their dogs innoculated rabies will never be eradicated", Dr Posthumus said. — Sapa.

/12851
CSO: 5400/80

BRIEFS

WHEAT CROPS INVADED--Wheat crops in 11 southern districts have been invaded by Hispa (Pamri Poka). Farmers of these districts have become mopish as they are unable to arrest the pests due to nonavailability of unadulterated pesticide and required numbers of sprayers. According to the Agriculture Extension Department, a massive programme was taken for cultivation of wheat on 1,88,884 acres in Barisal, Bhola, Jhalakati, Pirojpur, Barguna, Patuakhali, Faridpur, Rajbari, Madaripur, Shariatpur and Gopalgonj districts with a production target of 1,44,169 tons of wheat. It is learnt that production of Aus and Aman paddy was not satisfactory last season due to draught and flood in some areas of these districts. As such, farmers of the areas cultivated wheat in the present Rabi crop season of the hope with making goods their losses of Aus and Aman paddy. But pests have already damaged the wheat fields dashing their hopes to the ground. The farmers are trying to combat pests. But for want of required sprayers and pesticide, they cannot take any effective measure to control the pests. Agriculture Extension sources said, wheat on some 43,000 acres, which is about 30 percent of the total cultivated land, have already damaged by pests. If effective measures are not taken at the moment, the crop will totally be damaged, it is apprehended. Besides, it would be very difficult on the part of the farmers as well as the concerned authority to control the pests during the coming Irri season, if it was not contained at this stage. The affected farmers of the area have urged the authority concerned to undertake aerial spray of pesticide in the affected areas. [Text] [Dhaka THE NEW NATION in English 20 Jan 86 p 2] /13104

CSIL 5450/0115

FRANCE

CONCERN OVER FOREST DAMAGE INTENSIFIES

Analysis of Current Situation

Paris LE MONDE in French 5 Feb 86 p 19, 20

[Article by Roger Cans: "The Forests Under the Microscope"]

[Text] Are French forests sick, dying or convalescing? Asked in this manner by public opinion, the question makes no sense. In France, no forests exist, but rather a number of wooded stands with trees of varying age and species in each, growing under widely differing conditions.

In the Northern Vosges, the forester complains about the damage caused by wild game--deer or stags--whose teeth jeopardize any regeneration in some places. In the Mediterranean forest, where the fearsome cochineal matsucoccus has devoured 150,000 hectares of maritime pine, fire is especially a cause for concern now. In the Landes, where the fires of 1947 and 1949 burned nearly 400,000 hectares, it is the cold weather of January 1985 that killed the maritime pine precisely there where the scorched earth had been reforested with Portuguese seed, which is less resistant.

In Auvergne, no one will forget the November 1982 storm that, in 49 hours, ravaged 30,000 hectares and destroyed 6 million cubic meters! And now, after the acid rain alert, a pernicious evil is attacking the mountain forests: waldsterben (withering of the forest) which is striking Bavaria and the Black Forest in Germany.

It was in the summer of 1983 that the first damage "attributed to atmospheric pollution" was noticed. The fir trees, the pride of our mountains, were losing their needles. The spruce trees, usually so green, were beginning to turn yellow, even young seedlings. Some beech tree leaves were curling and turning red, as if from an invisible fire. What do do? Certainly this was not the first time that one saw fir trees shed. In the old plantings in the Vosges or the Jura, some trees traditionally had their tops turned into "storks' nests." But the symptoms of withering observed in young or old specimens was new. The yellowing of spruces or Scotch pines was also troubling: this chlorosis, sudden and unexplained, has caught foresters and researchers off guard.

Since autumn, observation sites have been set up in the Vosges, notably in the Donon stand of trees, which seems to be the most heavily affected. A square is arbitrarily designated in the forest; 24 adult trees are marked and are scored from 0 to 4 according to the percentage of foliage (or needles) they have lost. The foresters who keep the records--or "taxateurs" as they are called in Switzerland--fill out an index card per tree observed, with annotations possibly concerning soil, exposure, age, etc. Thus the forest's state of health is evaluated.

In 1984, the network of surveillance by sites was extended to Franche-Comte. In 1985, 29,000 trees were thus placed under observation in 1,200 sites (900 in national forests or those under National Forest Office management, 300 in private forests.) Besides the Vosges and the Jura, they are watching the Northern Alps, the Ardennes, Argonne, Haute-Normandie, Ile-de-France, Morvan, Aigoual and the central Pyrenees. The data are collected at CEMAGREF in Grenoble (National Agricultural Mechanization Center of Rural, Water and Forest Engineering), where a computer will collate all the results and deliver a first "health report" on French forests, which can be evaluated at a glance. This report was to have been furnished before the Silva conference, but the three people in charge of it at CEMAGREF were swamped with errors and code variations. We will have to wait several more weeks.

Measuring Background Noise

A preliminary manual examination by the National Forest Office (ONF) seems to show that, in the regions of the east where observations began in 1983 and where comparisons are therefore possible, "the situation remains worrisome but has not worsened." A slight improvement was even observed in Lorraine, where some trees are believed to have recovered their foliage because of the very wet past spring. Mr Martinot-Lagarde, technical director of ONF, concludes with this sentence: "I would say that the situation is stationary." This statement is almost identical to those in Swiss and West German official documents. He stresses that "the apparent increase in damage is just the result of the widening of the observation network." But he recognizes that some of the damage seen has been observed on conifers in Chartreuse and Vercors, where 27 percent of the firs and 9 percent of the spruces have lost more than a quarter of their needles.

"When one looks at the map of the stands of trees most heavily affected by withering, it is always the east that stands out," noted Mr Pierre Bouvarel, an expert on forests who has just retired from the National Forest Research Center near Nancy. "This would seem to confirm the hypothesis of atmospheric pollution carried by the west winds..." His colleague Maurice Bonneau, now operations manager of the DEPORPA program, does not argue with the "acid rain" hypothesis; but he sees it as only one factor among others, operating in conjunction with elements such as drought, often accompanied by a concentration of pollutants in the soil. He says: "I am very much afraid of the years 1986 and 1987 in the Massif Central," recalling the drought of September-October 1985 in the southern half of France.

The first report on the health of French forests, however, will be only an instant snapshot. We will have to wait several years for the regular report from the observation sites to give indications on the progress of their health// health. Furthermore, observations based only on color or loss of needles are not sufficient to give an account of the state of a tree. "People want to make the network say more than it can," objects Francoise Rolley, who is in charge of CEMAGREF's study of phytosanitary protection. "We are trying to measure something on the order to background noises."

This scepticism finds a broader echo in the forest management division of the Ministry of Agriculture. "We don't even know how a tree manages its stock of needles," observes Christian Barthod, head of the research and technology bureau. "It happens that a tree loses its needles before a rapid growth spurt. Others, which stay very green, do not grow any more. There is no obvious correlation between putting out leaves and growth." The director of forests, Francis Rincille, concludes: "Based on the preliminary results, I am no more worried than before, because I have been worried from the start. We have pulled several threads out of the ball of wool, and now we ask ourselves..." When will the answer come?

Forest Study Program Described

Paris LE MONDE in French 5 Feb 86 p 19

[Article by M.A.: "The DEFORPA Program"]

[Text] "Withering of forests attributed to atmospheric pollution" is the exact title of the DEFORPA program. Started in 1984 to evaluate the seriousness of attacks and to look into the causes, officially created by an order of 22 November 1985, it encompasses a group of projects accepted and evaluated by a scientific committee. Total financing is around 26 million francs over 2 years, 9 of which come from the EEC.

The projects are organized around four themes. The first is the measuring of effects. A remote sensing project has been carried out in the Vosges: analysis of results will be completed in summer 1986. We are expecting from it a better knowledge of needle loss and of the water-related status of trees, which is easily measurable through infrared observation.

The second theme is the study of pollutants. A measuring station has been installed in the Vosges, near Donon Pass. The measurements show that the rate of sulphur dioxide is generally low (15 micrograms per cubic meter or air), but can go up to 200 for short periods of time which hardly ever exceed 1 week per year. Analogous results are obtained for nitrogen oxides. On the other hand, ozone is found more frequently, especially during warm, sunny days.

A second station is to be installed at Aubure, on the border between the two Alsatian departments. Other projects are concerned with fine-tuning more precise or more easily used instruments. Studies which are underway on the effect of different pollutants rely particularly on growing young trees in a controlled atmosphere.

The third theme is the study of other foreseeable causes: climatic effects, attacks by different parasites. Finally, a fourth section gathers some "suggested solutions". Attempts at fertilization and research into more resistant species fall into this category.

SOUTH AFRICA

KAROO FARMERS BATTLE WORST LOCUST INVASION IN 20 YEARS

38 Districts Hit

Johannesburg THE STAR in English 26 Feb 86 p 23

[Article by Hannes de Wet]

[Text]

HOPETOWN — Plants of all kinds are being destroyed in 38 districts in the Karoo part of Northern Cape and South-Western Free State by the worst locust plague to hit the area for 20 years.

Mr Frannie Wiid, a farmer in the Hopetown district, said that large cotton and potato crops had been destroyed by the locusts — but their favourite food was mealies.

"It takes them only a few minutes to strip a mealie plant. When you look again only the stem of the plant remains," Mr Wiid said.

Mealie crops over an area of 50 ha on Mr Wiid's farm were ruined by the locusts.

Mr Wiid estimates the damage at between R6 000 and R7 000.

Another farmer, Mr Frankie du Toit, lost 8 000 morgen of veld.

Mr du Toit said he had nursed the veld for many months and it was heartbreaking to see it destroyed in a single night.

"This means that I will have to buy feed for my cattle for the coming season — unless it rains again," he said.

Mr du Toit, who is also the Mayor of Hopetown, said the district first suffered from the drought, then more than 5 000 sheep were lost because of cold weather. And now there were the locusts.

He added that there was no sign that the plague would be curbed in the immediate future.

"There are still thousands of grasshoppers around and I get the impression that not enough is being done to stop them," Mr du Toit said.

Mr Wiid explained that one of the main problems in combating the locusts was that some of the poison used to kill the insects also affected edible plants such as mealies, corn and potatoes.

"I have been farming in this area since 1954. This is the worst locust swarm I have ever seen. At times you get a big black cloud of locusts about two or three kilometres wide."

SADF Called In

Johannesburg THE STAR in English 24 Feb 86 p 1

[Text] CAPE TOWN — The Defence Force has been mobilised to help fight South Africa's lastest problem — one of the worst locust plagues in decades.

Deputy Agriculture Minister Mr G J Kotze says combating the outbreak is "a massive task", with thousands of people and aircraft already involved.

Now the Defence Force is coming in. Mr Kotze said: "Assistance by the Army will bring relief since a shortage of vehicles and reliable drivers/supervisors is creating serious problems."

The plague is centred in the Karoo, the northern Cape and south-western Free State. There has already been serious crop damage.

The Star's Africa News Service reports from Windhoek that Namibian authorities are working flat-out to combat a similar infestation of the pest in the south of the territory.

The locust swarms in South Africa are reported to have devoured hundreds of hectares of grazing land and are theatening OFS irrigation schemes.

Unemployed Help

Johannesburg THE STAR in English 25 Feb 86 p 17

[Text]

The South African Defence Force has moved into the veld and declared war on the worst brown locust plague South Africa has seen in 20 years.

Apart from the soldiers, an army of the unemployed have also been enlisted to help fight the brown locust, which threatens to destroy crops in 38 districts in the Karoo, parts of the Northern Cape and South Western Free State.

The Defence Force yesterday joined a team of 2 000 people battling the brown locust plague and their help will bring much-needed relief to the campaign to eradicate the pests, the Deputy Minister of Agricultural Economics, Mr Gert Kotze, said in a statement released in Cape Town.

There were 300 vehicle units, two helicopters, six aeroplanes and 2 000 people involved in the battle.

The SADF contributed 50 vehicles and drivers who joined the campaign yesterday.

Mr Isak Venter, deputy director of soil conservation for the Department of Agriculture and Economics, said there were huge locust populations covering extensive areas of as much as 100 km by 50 km. They were migrating northwards.

NO NEED FOR PANIC

The campaign was expected to continue until April/May, but at this stage there was no need for panic, he said.

Some swarms, which usually cover an area of 20 to 50 hectares, had escaped into Botswana near the Vryburg border. However, 350 control teams were at work fighting the plague.

Brown locusts had remained dormant during the severe drought, but with the drought-breaking rains had hatched and grown to plague proportions.

The Government had also set aside about R2 million in aid — as part of its scheme to alleviate unemployment — to assist the battle against the brown locust. Efforts to combat the outbreak were being severely hampered because large numbers of locusts were dispersed irregularly over thousands of hectares.

Reports of severe damage to the veld and crops centred mainly in the upper Orange and Vaal river irrigation areas with concentration points at Hopetown and Douglas, where maize crops were vulnerable.

With the means at its disposal, the Department of Agricultural Economics and Marketing was doing everything possible to keep the plague under control, said Mr Kotze.

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CSO: 5400/80

BRIEFS

CASSAVA DISEASE--Scarborough--Cassava sticks from Trinidad must not be used for planting in Tobago. A serious disease affecting cassava has been spreading in Trinidad, an official of the Agriculture Division of the Tobago House of Assembly has disclosed. However, the disease has not yet been detected in Tobago. The strong warning from the Agriculture Division that Tobago cassava growers must not, under any circumstances, plant cassava sticks which might have come from Trinidad is an attempt to prevent the spread of the disease, Cassava Bacterial Blight (CBB) to the sister island. Chemical control of CBB is virtually impossible, stated a news bulletin from the Agriculture Division. Symptoms of the disease include the wilting of young shoots, brown leaf spots which may be wet-looking and have a yellow band around them, appear on the underside of the leaves which will later roll up and dry up. Gum from the leaf spots and other cracks in stems and leaves will form yellowish shining scabs most easily seen under the leaves in the early morning. [Text] [Port-of-Spain EXPRESS in English 27 Feb 86 p 4] /9317

CSO: 5440/055

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9 April 86